



BlueCross BlueShield
of Illinois

HSA-Compatible Health Plans!

Blue Cross and Blue Shield of Illinois is pleased to offer high deductible health plans that are designed to be used with Health Savings Accounts (HSAs)

Two plans:

**BlueEdgeSM Individual HSA and
BlueEdgeSM Individual HSA 5000**

- A wide range of deductibles
- Low prices
- Highly competitive benefits with up to 100% coverage

**INDIVIDUAL AND FAMILY
HEALTH INSURANCE**

it just fits.

SM Service Marks of Health Care Service Corporation

® Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

® Registered Service Marks of Health Care Service Corporation

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

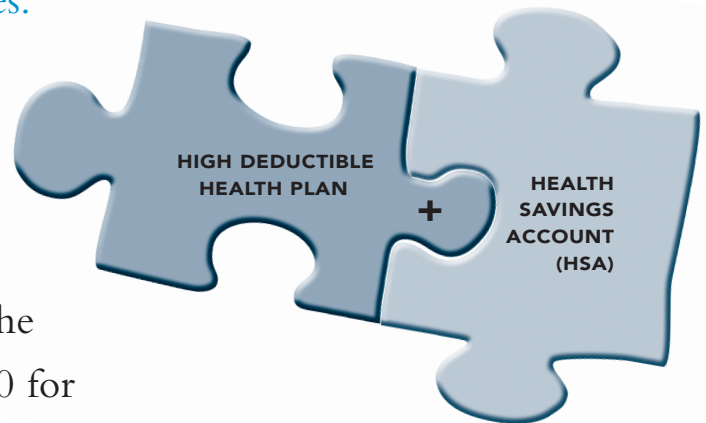
CONSUMER MARKETS

INDIVIDUAL & FAMILY HEALTH INSURANCE FROM BLUE CROSS AND BLUE SHIELD OF ILLINOIS

HSA Health Plans:

High deductible health insurance plans answer the need for reliable coverage with lower prices.

They typically cost less than major medical plans with lower deductibles, because you agree to assume a greater share of the cost of your health care expenses initially. The minimum annual deductible is \$1,050 for individuals and \$2,100 for families.



As of January 1, 2004, legislation passed by Congress made high deductible health plans even more attractive than ever — by allowing them to qualify for use with a Health Savings Account (HSA).^{*} This legislation is the result of a provision of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. An HSA is a tax-advantaged, individually owned savings account that you can use to cover a wide range of qualified medical expenses. These expenses may generally include your annual deductible and, if applicable, any out-of-pocket cost-sharing for covered services.

An HSA is similar to an individual retirement account (IRA), because funds can be invested in stocks, bonds and mutual funds while accumulating tax-free interest. The advantage of an HSA compared with an IRA is that HSA funds are generally not taxed when they are withdrawn to pay for qualified medical expenses.



In response to the federal legislation, Blue Cross and Blue Shield of Illinois has created innovative BlueEdge high deductible plans, which are designed to be used with an HSA.

^{*}Please be reminded that Health Savings Accounts (HSA) have tax and legal ramifications. Blue Cross and Blue Shield of Illinois does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.

More Advantages Than Ever!

Here are the major benefits of a Health Savings Account (HSA):

Control: The money in an HSA belongs to you. YOU decide how to spend it based on your particular health care needs and budget. HSA funds can be used to pay for qualified medical expenses not covered by your health insurance plan.

NOTE: Funds withdrawn other than for qualified medical expenses may be subject to tax and a 10% penalty.


Flexibility: You can deposit (generally until age 65) or withdraw your money *anytime* without a tax penalty as long as you use it for qualified medical expenses. There is a yearly maximum amount for contributions.

Ownership: The money in an HSA belongs to you. You can take it with you from one employer to another and continue to make contributions and withdrawals. Also, unused funds roll over from one year to the next.

Tax Savings*: An HSA allows you to put away money that may be fully tax deductible to cover future qualified medical expenses. This means that you can set aside income-tax-free dollars, subject to certain limits, in an HSA to pay for your qualified medical expenses. While your HSA builds savings, it also accumulates interest on a tax-free basis. You generally will pay no taxes or penalties when you use funds from your HSA to pay for qualified medical expenses.



**BlueCross BlueShield
of Illinois**



3 Easy Steps to Setting Up Your BlueEdge Health Plan and Health Savings Account (HSA)

STEP 1: Select and apply for one of the BlueEdge HSA plans.

- Choose the deductible and level of coverage that best fit your needs.
- Complete and mail in your application for the health plan.
- Start thinking about and determine which HSA you want to use in conjunction with your health plan.

STEP 2: Open a Health Savings Account (HSA) once your BlueEdge HSA health plan is activated.

- You may choose any HSA available to work in conjunction with your BlueEdge HSA health plan. Consider the associated fees, investment choices and debit card/checkbook options to determine which HSA is right for you.
- If you need direction on how to find an HSA, please contact your agent for more information.
- Fund your HSA as soon as possible in order to maximize your tax advantages for the year.

STEP 3: Pay for your qualified medical expenses out of your Health Savings Account (HSA).

- Most HSA providers will give you a checkbook and/or debit card so you can pay claims directly out of your HSA. These are convenient ways to pay for prescription or over-the-counter drugs. For doctor or hospital visits, we recommend that you ask to be billed later in case adjustments are made to your expenses.
- While you are not required to open an HSA to be used with your health plan, most customers agree that they get the most out of their plan by taking advantage of the tax benefits, control and flexibility of an HSA.

Innovative HSA-Compatible Plans

from Blue Cross and Blue Shield of Illinois

As the leading health insurer in Illinois, Blue Cross and Blue Shield of Illinois is always looking for innovative ways to help you satisfy your health insurance needs.



We are pleased to present **BlueEdge Individual HSA** and **BlueEdge Individual HSA 5000** — high deductible health insurance plans that can be used with a Health Savings Account (HSA).

Not only do both of our BlueEdge high deductible health products provide benefits for the same services as our top-of-the-line major medical plan...*they even offer more coverage than high deductible health plans from other companies.*

Of course, you can expect to find all the “standard” coverage of major medical plans — like benefits for hospitalization, surgery, doctor office visits, inpatient and outpatient care and emergency care. In fact, both **BlueEdge Individual HSA** and **BlueEdge Individual HSA 5000** offer up to \$5,000,000 in lifetime protection!

Check to see how many other plans offer these features:

- Optional maternity benefits
- Prescription drug coverage, well-child care and adult wellness
- 100% coverage after deductible as with **BlueEdge Individual HSA 5000**
- 100% or 80% coverage as with **BlueEdge Individual HSA**

Product Profiles

BlueEdge Individual HSA

- Choice of three deductibles for individuals: \$1,050, \$1,750 and \$2,600
- Choice of three deductibles for families: \$2,100, \$3,500 and \$5,200
- 100% or 80% coverage for service through participating providers
- When the out-of-pocket expense limits are reached, all covered benefits through participating providers are fully paid
- Prices reflect a 10% discount for families

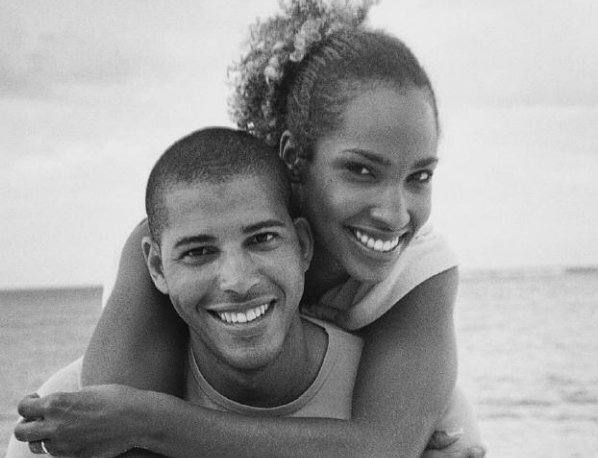
BlueEdge Individual HSA 5000

- \$5,000 deductible for individuals and \$10,000 deductible for families
- 100% coverage for services through participating providers (This means you pay nothing for covered services used through participating providers once you meet your deductible.)
- Prices reflect a 10% discount for families

Which BlueEdge HSA Insurance Plan Is Right for You?

Although there is no “right” answer to this question, here are some guidelines for helping you make an informed decision. If you are relatively young with a good health history, you may want to choose **BlueEdge Individual HSA 5000**. That’s because you may feel that you are unlikely to incur high health care expenses in any given year. Also, your monthly premium will be lower with this plan.

On the other hand, if you are willing to pay a little more for your monthly premiums in return for a lower annual deductible — as low as \$1,050 for individuals — you may want to consider **BlueEdge Individual HSA**.



Getting the Facts on High Deductible Health

Q. What is a high deductible health plan?

A. A high deductible health plan is a health insurance plan that features an annual deductible ranging from \$1,050 to \$5,250 for individuals and from \$2,100 to \$10,500 for families. Because the deductible is high, monthly premiums are typically lower than they are for other health plans. What's more, certain high deductible health plans — like **BlueEdge Individual HSA** and **BlueEdge Individual HSA 5000** from Blue Cross and Blue Shield of Illinois — are designed to be used with a Health Savings Account (HSA), which may offer you tax advantages and greater control of how you spend your money for health care expenses.

Q. What is an HSA?

A. An HSA, or Health Savings Account, is a tax-advantaged, individually owned savings account that you can use with a high deductible health plan to cover a wide range of qualified medical expenses. That includes your annual deductible and, if applicable, any out-of-pocket cost-sharing for covered services.

Q. Who is eligible for an HSA*?

A. Individuals, generally those under age 65, who are covered by a qualified high deductible health plan — and who are not (a) covered by other health insurance or health benefit plan, or (b) entitled to or currently enrolled in Medicare (typically at age 65) — can qualify. You cannot be claimed as a dependent on someone else's tax return.

Q. Do I have to set up an HSA before I start paying for my medical expenses?

A. If you want to take full advantage of a high deductible health plan that is designed for an HSA — like **BlueEdge Individual HSA** or **BlueEdge Individual HSA 5000** from Blue Cross and Blue Shield of Illinois — the answer is “Yes.”

Q. How do I set up an HSA*?

A. Your Blue Cross and Blue Shield of Illinois agent can provide you with information to help you set up an HSA. Or, you may already have a particular financial institution in mind.

Q. How much can I contribute to my HSA?

A. Each year, individuals can contribute up to \$2,700 or the amount of their plan's annual deductible — whichever amount is lower. Families can contribute up to \$5,450 or the amount of their plan's deductible — whichever amount is lower.**

Q. How do I contribute to my HSA*?

A. Within limits, you may contribute money to your account by making a lump sum contribution or periodic payments at any time. You can claim your total amount contributed for the year as an “above the line” tax deduction when you file your income taxes. You have until April 15 of the following year to make HSA contributions for the prior year. If you are over age 55, you can make additional catch-up contributions.

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** These amounts are adjusted by the IRS annually for inflation.

Insurance Plans and Health Savings Accounts (HSAs)*

Q. How do I use the funds in my HSA?

A. Using funds in your HSA is easy. Typically, a financial institution will provide you with a debit card and/or a checkbook. When you pay for a qualified medical expense, use the debit card or check to make the payment.

Q. What are qualified medical expenses?

A. An HSA can be used to pay for many types of qualified medical expenses, even some that are often excluded through health insurance plans. Here is a partial list of what's included:

- Health insurance plan deductibles, copayments and coinsurance paid for qualified medical expenses
- Prescription and most over-the-counter drugs
- Dental services, including braces, bridges and crowns
- Vision care, including glasses and Lasik eye surgery
- Psychiatric and certain psychological treatments
- Qualified long-term care services and insurance premiums (subject to limits based on age and are adjusted annually)[†]
- Medically related transportation and lodging (subject to certain limitations)

Check with your tax advisor or go to www.irs.gov to obtain a current list of qualified medical expenses as determined by the IRS. (See Publication 502 and 969)

Q. Can I use my HSA to pay for non-health-related expenses*?

A. You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and, if you are under 65 years old, there is generally an additional 10 percent tax penalty on the amount withdrawn.

Q. Can the unused funds in my HSA be rolled over each year?

A. Yes. Your funds will accumulate without a maximum limit.

Q. Does the money in my HSA earn interest?

A. In most cases, the funds in your HSA will earn interest. Many financial institutions that offer HSAs will also have other investment options.

Q. How long can I keep my HSA?

A. Your HSA is yours to *own*. You can take it from one job to the next, and you can even use it when you retire.

Q. Can an HSA be used by individuals over age 65?

A. Yes. Although individuals over age 65 generally may not contribute to their HSA, they may continue to earn tax-free interest on the balance and can use their account to pay for health-related medical expenses tax-free.

[†]Note: Generally, an HSA may not be used to purchase health insurance unless specifically excepted. Expenses that are not qualified medical expenses include premiums paid for Medicare supplemental coverage and Medigap. To be sure if a medical expense qualifies as eligible, you should check with a tax advisor or the IRS.



See Why More Than 4 Million Illinois Residents Choose Blue Cross and Blue Shield of Illinois

The Size and Strength of the Contracting Provider Network Assure You Freedom of Choice

BlueEdge Individual HSA and **BlueEdge Individual HSA 5000** provide access to one of the largest contracting provider networks in Illinois. In fact, with 90% of Illinois doctors included — as well as more than 200 hospitals — it's likely that your current health care providers participate.

Blue Cross and Blue Shield of Illinois Offers You and Eligible Family Members Choices

Blue Cross and Blue Shield of Illinois offers you and eligible family members choices when it comes to your care. Members and eligible dependents have the freedom to visit any physician they choose, with benefits paid at the highest level of benefits when the doctor is in the participating provider network. Members do not need to select a primary care physician to coordinate care, and no referrals are needed to see a specialist.

Travel with Confidence — You're Covered Away from Home

As a member of Blue Cross and Blue Shield of Illinois, you'll have access to a program called BlueCard PPO. Contracting providers linked through the BlueCard program allow you to receive benefits for covered services when you travel. Simply present your Blue Cross and Blue Shield of Illinois ID card to a participating provider wherever you are. To find a participating provider while you're away, just call the toll-free number on the back of your card. It's that easy.

No Paperwork in Most Cases — Your Claims Are Handled for You

- Simply present your BlueEdge HSA ID card to your health care provider. Do not make a payment at this time.
- Your health care provider will submit a claim to Blue Cross and Blue Shield of Illinois.
- Blue Cross and Blue Shield of Illinois will send you an Explanation of Benefits — which will also show you how much of your deductible and your out-of-pocket maximum you have met to date.



Our *Members First*[®] Discount Program

Helps You Save Money on Dental, Vision,
Hearing and Chiropractic Care Services!

Guaranteed Renewability

Your individual or family coverage is guaranteed to be renewable.

This means that as long as your premiums are paid on time, renewal of your coverage can be refused only for the following reasons:

(1) fraud or an intentional material misrepresentation, or (2) all policies bearing your policy's form number have not been renewed.

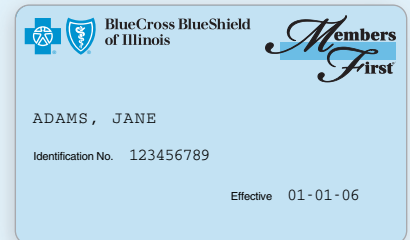
Financial Stability You Can Count On

Today, one American out of three carries a Blue Cross and Blue Shield membership card. In fact, more than 4 million residents across Illinois carry our membership card because they trust Blue Cross and Blue Shield of Illinois to give them more health care value for their premium dollar. Blue Cross and Blue Shield of Illinois has been serving the health insurance needs of Illinois residents for more than 65 years. We're one of the largest and most financially secure insurance companies in the state. A.M. Best, one of the leading rating agencies of the insurance industry, has awarded us an "A+" (Superior) rating.*

* As of June 2005

Members First[®] can save you hundreds of dollars a year on products and services you use every day.

Because this isn't insurance, this program costs you nothing extra. It's just our way of saying "thank you" for being a member.



- The Dental Program saves you as much as 50% on routine and preventive dental services when you go to one of the many participating providers throughout the entire United States — over 15,000 nationwide. You'll receive your discount at the time of service.
- The Vision Program guarantees savings of as much as 50% on eyeglasses and contact lenses at participating eyecare centers nationwide, including LensCrafters, Sears, JCPenney and Pearle Vision.
- The Hearing Program provides savings on hearing aids and a variety of other products and services from the largest network of audiologists in the United States. You'll receive a discount of as much as 20% on conventional hearing aids.
- The Chiropractic Program emphasizes wellness and preventive health care at special rates from participating providers. Your initial exam is just \$35, and there's no limit on the number of visits. Go to the chiropractor as often as you need for immediate savings of as much as 40% off chiropractic care.
- The Vitamin Program offers a variety of vitamins and nutritional supplements at savings of 25% to 50% off already-low catalog prices.
- The Liberty Diabetes Care Plan provides savings and no-charge home delivery of diabetes testing supplies.
- Grocery store coupons with no expiration dates help you save over \$350 on brand-name products at your local supermarket.



MEMBERS FIRST: AN EXCLUSIVE PRIVILEGE
OF BLUE CROSS AND BLUE SHIELD OF ILLINOIS MEMBERSHIP

BENEFITS COMPARISON

BlueEdge Individual HSA & BlueEdge

BENEFIT	BlueEdge Individual HSA ¹	BlueEdge Individual HSA 5000 ¹
	Participating Provider Coverage	Participating Provider Coverage
Provider Network	90% of Illinois doctors; more than 200 hospitals	
Lifetime Benefit	\$5,000,000	
Individual Coverage Deductible Per calendar year	\$1,050, \$1,750 or \$2,600	\$5,000
Individual Out-of-Pocket Expense Limit	Annual deductible plus \$3,000 ²	Annual deductible
Family Coverage Deductible Per calendar year	Equal to two times the individual deductible	
Family Aggregate Out-of-Pocket Expense Limit Equal to two times the individual out-of-pocket limit per family, per calendar year	Annual deductible plus \$6,000 ²	Annual deductible
Hospital Services		
• Inpatient Physician Services	100% or 80%	100%
• Outpatient Services Includes surgery and pre-admission testing	100% or 80%	100%
• Inpatient Services Includes semi-private room and board, pre-admission testing, prescription drugs and more	100% or 80%	100%
• Inpatient/Outpatient Diagnostic Testing Includes X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies and more	100% or 80%	100%
Wellness Care From age 16. Covers services associated with both an annual physical exam and an annual gynecological exam. Includes immunizations and routine diagnostic tests received or ordered on the same day as part of the exam. (\$500 calendar-year maximum per person)	100% or 80%	100%
Well-Child Care To age 16. Includes immunizations, physical exams and routine diagnostic tests. (\$500 calendar-year maximum per dependent)	100% or 80%	100%
Outpatient Emergency Care Includes covered services received in a hospital or a physician's office	100% or 80%	100%

Individual HSA 5000

BENEFIT	BlueEdge Individual HSA ¹	BlueEdge Individual HSA 5000 ¹
	Participating Provider Coverage	Participating Provider Coverage
Physical, Occupational or Speech Therapist ((\$3,000 maximum per therapy, per calendar year)	100% or 80%	100%
Outpatient Prescription Drugs	100% or 80%	100%
Mental Illness Treatment and Substance Abuse Rehabilitation Treatment <i>Inpatient Care</i> (30 Inpatient Hospital days per calendar year)		
• Physician	100% or 80%	100%
• Hospital — First 14 days	60%	100%
Thereafter	50%	100%
<i>Outpatient Care</i> (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum)		
• Physician and Hospital	50%	100%
Optional Maternity Coverage Inpatient/Outpatient Hospital Services and Physician Medical/Surgical Services <i>When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage</i>	100% or 80%	100%

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² The individual out-of-pocket expense plus individual deductible cannot exceed \$5,000. The family aggregate out-of-pocket expense plus family deductible cannot exceed \$10,000.

Maximizing Your Benefits Can Be Just a Phone Call Away!

Blue Cross and Blue Shield of Illinois can assist you in trying to maximize your benefit coverage. That’s why our health insurance plans include the services of two units. They’re called the Mental Health Unit and the Medical Services Advisory (MSA®).

Call one of these units whenever you need mental health and substance abuse services, or if you find yourself receiving treatment at an out-of-network hospital. They can assist you in maximizing your available benefits.



BlueEdge® Individual HSA With Your Choice of Deductibles and Participating Provider Coinsurance Levels.

OUTLINE OF COVERAGE

- 1. READ YOUR POLICY CAREFULLY** — This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. BlueEdge Individual HSA Coverage** — BlueEdge Individual HSA coverage is designed to provide you with economic incentives for using designated health care providers. It provides, to persons insured, coverage for

major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services and Out-of-Hospital care, subject to any deductibles or other limitations which may be set forth in the Policy. **Although you can go to the Hospitals and Physicians of your choice, your benefits under the BlueEdge Individual HSA plan will be greater when you use the services of participating Hospitals and Physicians.**

BASIC PROVISIONS	BlueEdge Individual HSA	
	Participating Provider Coverage	Non-Participating Provider Coverage
Lifetime Benefit	\$5,000,000	
Individual Coverage Deductible Per calendar year.	\$1,050 [†] \$1,750 \$2,600	
Family Coverage Deductible Per calendar year.	Equal to two times the individual deductible	
Hospital Admission Deductible Per admission, per individual.	\$0	\$300
Coinsurance The level of coverage provided by the plan after the calendar-year Deductible has been satisfied. You must select a level of participating provider coverage: 100% participating provider coverage, or 80% participating provider coverage	100% ----- 80%	80% ----- 60%
Individual Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Items asterisked (*) <u>do not</u> apply to the out-of-pocket expense limit.	Annual deductible plus \$3,000 ^{**}	Annual deductible plus \$6,000
Family Aggregate Out-of-Pocket Expense Limit Equal to two times the individual out-of-pocket limit, per family, per calendar year.	Annual deductible plus \$6,000 ^{**}	Annual deductible plus \$12,000

[†] The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.

^{**} The individual out-of-pocket expense plus individual deductible can not exceed \$5,000. The family aggregate out-of-pocket expense plus family deductible can not exceed \$10,000.

BASIC PROVISIONS	BlueEdge Individual HSA	
	Participating Provider Coverage	Non-Participating Provider Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	100% ----- 80%	80% ----- 60%
Wellness Care From age 16. Covers services associated with both an annual physical exam and an annual gynecological exam. Includes immunizations and routine diagnostic tests received or ordered on the same day as the exam. (\$500 calendar-year maximum, per person.)	100% ----- 80%	80% ----- 60%
Well-Child Care To age 16. Includes immunizations, physical exams and routine diagnostic tests. (\$500 calendar-year maximum, per dependent.)	100% ----- 80%	80% ----- 60%
Inpatient/Outpatient Hospital Services Includes surgery, preadmission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	100% ----- 80%	80% ----- 60%
Inpatient/Outpatient Hospital Diagnostic Services Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests and electromyograms.	100% ----- 80%	80% ----- 60%
Physical, Occupational, and Speech Therapist Services (\$3,000 maximum per therapy, per calendar year.)	100% ----- 80%	80% ----- 60%
Temporomandibular Joint Dysfunction and Related Disorders (\$1,000 lifetime maximum.)	100% ----- 80%	80% ----- 60%
Muscle Manipulations Rendered by a Physician or Chiropractor (\$1,000 per calendar year.)	100% ----- 80%	80% ----- 60%
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. <i>When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.</i>	100% ----- 80%	80% ----- 60%
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	----- 100% ----- 80%	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%	80%
Durable Medical Equipment (DME) (\$1,000 per month maximum.)	100% ----- 80%	80% ----- 60%
Other Covered Services Ambulance services; services of a private duty nursing service (\$1,000 per month maximum); naprapathic services rendered by a Naprapath (\$1,000 per calendar-year maximum); artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; leg, arm and neck braces; surgical dressings; casts and splints.	----- 100% ----- 80%	
Outpatient Prescription Drugs	----- 100% ----- 80%	

BASIC PROVISIONS	BlueEdge Individual HSA	
	Participating Provider Coverage	Non-Participating Provider Coverage
<p>Mental Illness Treatment and Substance Abuse Rehabilitation Treatment</p> <p>Inpatient Care (30 Inpatient Hospital days per calendar year.)</p> <p>Physician</p> <p>Hospital First 14 days Thereafter</p> <p>Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)</p> <p>Physician and Hospital</p>	<p>100%</p> <p>-----</p> <p>80%</p> <p>60%</p> <p>50%</p> <p>50%</p> <p>50%</p>	<p>80%</p> <p>60%</p> <p>50%</p> <p>50%</p> <p>50%</p>
<p>Medical Services Advisory (MSA®)</p> <p>The MSA helps you maximize your benefits.</p>	<p>The Participating Provider is responsible for notifying MSA when services are rendered in a Participating Hospital.</p>	<p>The Policyholder is responsible for notifying MSA for Hospital admissions at Non-Participating and Non-Plan Hospitals.</p> <p>MSA notification is required within three business days for non-emergencies and within one business day or as soon as reasonably possible for emergencies and maternity admissions. If Policyholder does not notify MSA, the Policyholder will then be responsible for the first \$1,000 or 50% of the Hospital charge, whichever is less.</p>
<p>Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours or as soon as reasonably possible for emergencies. If Policyholder does not notify the Mental Health Unit, the Policyholder will then be responsible for the first \$1,000 or 50% of the Hospital charge, whichever is less.</p>		

* Does not apply to out-of-pocket expense limit.

IF USING A NON-PLAN PROVIDER... A \$300 per Hospital admission Deductible will apply. If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 80% regardless of your coverage level or whether services were received from a Participating, Non-Participating or Non-Plan Provider.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-50 HCSC policies. Premiums can be changed based on age, sex and rating area.

COST OF LIVING ADJUSTMENT (COLA) The deductible and/or out-of-pocket expense amounts may be adjusted for inflation based on the Consumer Price Index or other index used by the Federal Government and rounded up to the nearest \$50 increment.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

- A. If all Policies bearing form number DB-50 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
- B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

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Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; Services or supplies that do not meet accepted standards of medical or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned

in this Policy; Eyeglasses, contact lenses, or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness); Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prosthesis); and Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.



**BlueCross BlueShield
of Illinois**

Correction

No Monthly Maximum for Durable Medical Equipment (DME)

Please note that for Durable Medical Equipment there is no monthly maximum under the BlueEdgeSM Individual HSA plan. Please disregard the statement in the Outline of Coverage that there is a \$1,000 per month maximum.

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee
of the Blue Cross and Blue Shield Association

CONSUMER MARKETS

® Registered Service Marks of the Blue Cross and Blue Shield Association,
An Association of Independent Blue Cross and Blue Shield Plans

SM Service Mark of Health Care Service Corporation



BlueEdge® Individual HSA 5000

OUTLINE OF COVERAGE

1. **READ YOUR POLICY CAREFULLY** — This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
2. **BlueEdge Individual HSA 5000 Coverage** — BlueEdge Individual HSA 5000 coverage is designed to provide you with economic incentives for using designated health care providers. It provides, to persons insured, coverage for

major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services and Out-of-Hospital care, subject to any deductibles or other limitations which may be set forth in the Policy. **Although you can go to the Hospitals and Physicians of your choice, your Hospital benefits under the BlueEdge Individual HSA 5000 plan will be greater when you use the services of participating Hospitals and Physicians.**

BASIC PROVISIONS	BlueEdge Individual HSA 5000	
	Participating Provider Coverage	Non-Participating Provider Coverage
Lifetime Benefit	\$5,000,000	
Individual Coverage Deductible Per calendar year.	\$5,000	
Family Coverage Deductible Per calendar year.	Equal to two times the individual deductible	
Hospital Admission Deductible Per admission, per individual.	\$0	\$300
Coinsurance The level of coverage provided by the plan after the calendar-year Deductible has been satisfied.	100%	80%
Individual Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Items asterisked (*) <u>do not</u> apply to the out-of-pocket expense limit.	Your annual deductible	Your annual deductible plus \$5,000
Family Aggregate Out-of-Pocket Expense Limit Equal to two times the individual out-of-pocket limit, per family, per calendar year.	Your annual deductible	Your annual deductible plus \$10,000

BASIC PROVISIONS	BlueEdge Individual HSA 5000	
	Participating Provider Coverage	Non-Participating Provider Coverage
Inpatient/Outpatient Physician Medical/Surgical Services	100%	80%
Wellness Care From age 16. Covers services associated with both an annual physical exam and an annual gynecological exam. Includes immunizations and routine diagnostic tests received or ordered on the same day as the exam. (\$500 calendar-year maximum, per person.)	100%	80%
Well-Child Care To age 16. Includes immunizations, physical exams and routine diagnostic tests. (\$500 calendar-year maximum, per dependent.)	100%	80%
Inpatient/Outpatient Hospital Services Includes surgery, preadmission testing and services received in a skilled nursing facility, coordinated home care program and hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)	100%	80%
Inpatient/Outpatient Hospital Diagnostic Services Includes, but not limited to, X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests and electromyograms.	100%	80%
Physical, Occupational, and Speech Therapist Services (\$3,000 maximum per therapy, per calendar year.)	100%	80%
Temporomandibular Joint Dysfunction and Related Disorders (\$1,000 lifetime maximum.)	100%	80%
Muscle Manipulations Rendered by a Physician or Chiropractor (\$1,000 per calendar year.)	100%	80%
Optional Maternity Coverage Inpatient/Outpatient Hospital services and Physician Medical/Surgical services. <i>When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.</i>	100%	80%
Outpatient Emergency Care (Accident or Illness) For both Hospital and Physician.	100%	
Additional Surgical Opinion Program Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.	100%	80%
Durable Medical Equipment (DME) (\$1,000 per month maximum.)	100%	80%
Other Covered Services Ambulance services; services of a private duty nursing service (\$1,000 per month maximum); naprapathic services rendered by a Naprapath (\$1,000 per calendar-year maximum); artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; leg, arm and neck braces; surgical dressings; casts and splints.	100%	
Outpatient Prescription Drugs	100%	

BASIC PROVISIONS	BlueEdge Individual HSA 5000	
	Participating Provider Coverage	Non-Participating Provider Coverage
<p>Mental Illness Treatment and Substance Abuse Rehabilitation Treatment</p> <p>Inpatient Care (30 Inpatient Hospital days per calendar year.)</p> <p>Physician</p> <p>Hospital First 14 days Thereafter</p> <p>Outpatient Care (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)</p> <p>Physician and Hospital</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>80%</p> <p>50%</p> <p>50%</p> <p>50%</p>
<p>Medical Services Advisory (MSA®) The MSA helps you maximize your benefits.</p>	<p>The Participating Provider is responsible for notifying MSA when services are rendered in a Participating Hospital.</p>	<p>The Policyholder is responsible for notifying MSA for Hospital admissions at Non-Participating and Non-Plan Hospitals.</p> <p>MSA notification is required within three business days for non-emergencies and within one business day or as soon as reasonably possible for emergencies and maternity admissions. If Policyholder does not notify MSA, the Policyholder will then be responsible for the first \$1,000 or 50% of the Hospital charge, whichever is less.</p>
<p>Mental Health Unit In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours or as soon as reasonably possible for emergencies. If Policyholder does not notify the Mental Health Unit, the Policyholder will then be responsible for the first \$1,000 or 50% of the Hospital charge, whichever is less.</p>		

* Does not apply to out-of-pocket expense limit.

IF USING A NON-PLAN PROVIDER... A \$300 per Hospital admission Deductible will apply. If using a Non-Plan Provider, benefits are reduced to 50%. However, Outpatient Hospital emergency care is paid at 100% regardless of your coverage level or whether services were received from a Participating, Non-Participating or Non-Plan Provider.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-51 HCSC policies. Premiums can be changed based on age, sex and rating area.

COST OF LIVING ADJUSTMENT (COLA) The deductible and/or out-of-pocket expense amounts may be adjusted for inflation based on the Consumer Price Index or other index used by the Federal Government and rounded up to the nearest \$50 increment.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

- A. If all Policies bearing form number DB-51 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.
- B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

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Exclusions and Limitations:

Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits except where not required by law; Services or supplies that are furnished to you by the local, state, or federal government; Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; Services or supplies that do not meet accepted standards of medical or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; Eyeglasses, contact lenses, or cataract lenses and the

examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness); Long Term Care; Inpatient Private Duty Nursing Service; Maintenance Care; Wigs (also referred to as cranial prosthesis); and Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Policy.

Application Instructions

Please print the all attached forms (8 pages not including this) and complete them by hand.

Assure quick processing of all applications, please make sure you have completed the following:

1. Reviewed each application to verify that is complete and legible.
2. Assured that the necessary signatures are provided?
3. Assured that any changes to an application are initialed by the applicant?
4. Attached detailed descriptions for any health questions which have been answered "yes"?
5. Included your Agent Code(NOT THE SAME AS SHELTER ID) and phone number on the application?
6. Completed the "Conditional Receipt" form?
7. Given the applicant a copy of the Outline Of Coverage?
8. The check for the exact amount should be made payable to: Blue Cross & Blue Shield of Illinois (NO Agency Checks).

If the applicant is paying by bank draft authorization make sure the authorization form is completed, a voided check or deposit slip is attached, and a check for the first months premium should be submitted.

If the applicant is selecting the two-month payment mode, a check for the first two months' premium should be submitted.

9. If applicant is replacing his/her current coverage make sure a signed replacement form is attached.

After completing the above checklist:

- 1) Please complete all the above, and mail directly to Gateway Insurance Marketing at the address below:

Gateway Insurance Marketing
Attn: BCBS Illinois New Business
PO Box 550
Stockton, MO 65785

Important: Be sure to Submit all forms together
(Do Not Include This Page)

For more information or questions, please contact Gateway Insurance Marketing at 800-979-6711. You may also email us at damiengs@ipa.net

APPLICATION FOR INDIVIDUAL COVERAGE



HOME OFFICE USE ONLY

To help us process your application promptly, please remember to:

- Print all answers in **black ink**. Pencil will not be accepted.
- Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.
- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid.

CWA:	
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Please be reminded that Health Savings Accounts (HSA) have tax and legal ramifications. Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois, does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. Please consult your tax advisors for information regarding the tax consequences of specific health insurance plans or products.

PART ONE Check one: New Policy Add Dependent Upgrade (increase of benefits)

SECTION A — PERSON(S) APPLYING FOR COVERAGE (please print)

In addition to having a permanent residence in Illinois, all persons applying for coverage who are not U.S. citizens must have resided in the U.S. for at least six months **AND** have had a complete physical by a physician in the U.S. within the past two years.

PRIMARY APPLICANT

First Name, Middle Initial, Last Name		Social Security # - -	Sex (m/f)	Age	Date of Birth (mo./day/yr.) / /	Height (ft., in.)	Weight (lbs.)
Home Phone # ()	Business Phone # ()	Fax # (if available) ()	Occupation/Duties		Spouse's Business Phone # () (if applying)		
Residence Street Address			City / State / ZIP			County	
Email (if available)					Best place and time to call (if necessary) <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		

SPOUSE and DEPENDENT CHILDREN YOU WISH TO COVER (dependent children must be under age 19, or under age 25 if unmarried, full-time student)

NAME: First	M.I.	Last	RELATION (spouse or child)	SEX	HEIGHT (ft., in.)	WEIGHT (lbs.)	DATE OF BIRTH (mo/day/yr)	SOCIAL SECURITY NUMBER	FULL-TIME STUDENT
				<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION B — COVERAGE APPLIED FOR (please choose only one plan)

BlueEdge® Individual HSA

Deductible: \$1,050 for a single applicant or \$2,100 for a family*
 \$1,750 for a single applicant or \$3,500 for a family
 \$2,600 for a single applicant or \$5,200 for a family
 Level of Coverage: 100% 80%
 Do You Want Maternity Coverage? Yes

BlueEdge® Individual HSA 5000

Deductible: \$5,000 for a single applicant or \$10,000 for a family
 Level of Coverage: 100%
 Do You Want Maternity Coverage? Yes

SECTION C — BILLING INFORMATION

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

REQUESTED EFFECTIVE DATE (mo./day/yr.) _____ PREMIUM AMOUNT ENCLOSED \$ _____

- PREMIUM MODE: Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
 Two-Month Direct Bill
 List Bill (Submit a "Personal Health Insurance Certification for Employees" form with the application)

Billing Name and Address (if different than name and residence address given above)	Name of Employer (if requesting List Bill only)
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*The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.

PART TWO — EVIDENCE OF INSURABILITY

All health history/medical questions must be completed for all individuals (including dependents) applying for coverage.

SECTION A — HEALTH HISTORY / MEDICAL QUESTIONS

If you answer "Yes" to ANY questions on this page, please give complete details on the next page. Please note the timeframe reference for each question.

1. Has any person applying for coverage been advised to seek treatment for alcohol use or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism **within the last 10 years**? Yes No
2. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use or dependency **within the last 10 years**? Yes No
3. **Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last 10 years for the following:** Please check Yes or No. *If any boxes are checked "Yes" (Yes), also circle the condition, e.g. (migraines), and give details on the next page.*
 - A. Migraines; headaches; carpal tunnel syndrome; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? Yes No
 - B. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? Yes No
 - C. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? Yes No
If "Yes" to HBP, provide 3 readings and their dates w/in the last year
_____ and _____ and _____
 - D. Varicose veins/spider veins/varicosities; elevated cholesterol or lipids; anemia; blood clot or any other blood disorder? Yes No
 - E. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; or any breathing difficulty, lung or respiratory disease, disorder or condition? Yes No
 - F. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach or duodenum, or any other digestive disorder or condition? Yes No
 - G. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? (indicate type of hepatitis _____) Yes No
 - H. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? (indicate diagnosis and location _____) Yes No
 - I. Acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other skin disorder? Yes No
 - J. Kidney stones; reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? Yes No
 - K. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? Yes No
 - L. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; bunions; joint replacement; or manipulation therapy? Yes No
 - M. Thyroid disorder; goiter; Graves disease; diabetes; lupus; pituitary or adrenal disorder? Yes No
 - N. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? Yes No
 - O. Acquired Immune Deficiency Syndrome (AIDS); AIDS-Related Complex (ARC); HIV positive or other immune disorders? Yes No
 - P. *Question for Male Applicants and Dependents Only*
Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? Yes No
 - Q. *Question for Female Applicants and Dependents Only*
Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? Yes No

QUESTION CONTINUES AT RIGHT

4. **During the last 5 years**, has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist? Yes No
5. Has any person applying for coverage been prescribed or taken any medication due to any sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss **in the last 12 months**? Yes No
6. Have you or your spouse (if to be insured) smoked or used any tobacco products – such as cigarettes, pipes, cigars, snuff or chewing tobacco – **in the last 12 months**?
YOU Yes No
YOUR SPOUSE Yes No
7. A. *Question for Female Applicants and Dependents Only:* Is any female applying for coverage now pregnant? Yes No
B. *Question for Male Applicants and Dependents Only:* Is any male applying for coverage now an expectant parent? Yes No
If "Yes" to either question, coverage cannot be offered.
8. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin or penile implant), internal fixation (e.g. pins, plates or screws), prosthesis, pacemaker, valve replacement, shunt or monitoring device? Yes No
9. Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery **which has not yet been performed**? Yes No
10. Has any person applying for coverage **ever** been hospitalized or been treated in the emergency room or had any physical impairment, deformity, congenital anomaly, sickness, operation, injury or hospitalization **other than** admitted to on this page? Yes No

PART TWO — CONTINUED

SECTION B — DETAILS OF HEALTH HISTORY

If you answered “Yes” to ANY questions on the previous page, please provide further information using the chart below. Be sure to use the “correct” example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

	Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment, Advice Given, and Medications Prescribed	Name, Address and Phone Number of Doctors and Hospitals
			What is it?	Date that it Started	Date of Recovery (if applicable)			
Incorrect Example:	C	Mr. Smith	blood pressure	1995	N/A	N/A	prescription	Dr. Jones St. Mary's Hospital
Correct Example:	3C	Joe Smith	high blood pressure	6/95	none	no, ongoing	40mg Atenolol once a day 140/80 - 7/8/01 138/78 - 10/12/01 139/77 - 2/9/02	Dr. Jones St. Mary's Peoria, IL (309) 555-1212

If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)?..... Yes No

SECTION C — OTHER INSURANCE INFORMATION

- Does any person applying for coverage currently have, or did they previously have, Blue Cross and Blue Shield of Illinois coverage, either as a primary insured or as a dependent? Yes No *If “Yes”, please complete the following:*
 Member Name _____ Member No. _____ Group No. _____
- Does any person to be covered have any Major Medical, HMO, or PPO Medical Insurance with any other Insurer? Yes No
- Will the issuance of this coverage cause you to discontinue your existing coverage? Yes No
If “Yes”, when is coverage to be discontinued (mo./day/yr.)? _____ / _____ / _____ (Note: A Notice of Replacement Form must also be submitted with your application, even if replacing Blue Cross and Blue Shield of Illinois coverage.)
If “No”, please explain _____
- Has any person applying for coverage ever been declined, postponed, charged an extra premium for or had a rider applied to life, health, or disability insurance, or had any such insurance rescinded? Yes No
If “Yes”, please explain _____

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

PART THREE

SECTION A — REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I apply for coverage as indicated in PART ONE, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical coverage) which is herein called the Company. **I have read all the statements in PARTS ONE and TWO, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on PARTS ONE and TWO of this application may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of the Company.**

I have read and understand the Outline of Coverage that has been provided to me by my agent who sells Blue Cross and Blue Shield of Illinois insurance plans. My agent has informed me of the provisions of the Blue Cross and Blue Shield of Illinois health plan and the Medical Services Advisory (MSA[®]) Program (along with the provisions of the Mental Health Unit if applicable).

I understand that the insurance plan applied for is **not** an employer-sponsored group health plan and it **does not** comply with state or federal small employer laws, even if I have requested List Bill.

If requesting List Bill, I direct my employer to deduct from my pay and remit the entire cost of the coverage selected. This authorization is to remain in effect until the Company is notified by me or my employer in writing to the contrary.

Medical Authorization: I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

IMPORTANT: Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant's Signature: **X** _____ Date Signed: _____ / _____ / _____
mo. day yr.

Spouse's Signature (ONLY if to be insured): **X** _____ Date Signed: _____ / _____ / _____
mo. day yr.

Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): **X** _____ Date Signed: _____ / _____ / _____
mo. day yr.

Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): **X** _____ Date Signed: _____ / _____ / _____
mo. day yr.

Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): **X** _____ Date Signed: _____ / _____ / _____
mo. day yr.

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Primary Applicant's Signature: **X** _____

Print Your Name as You Signed It: _____ Date Signed: _____ / _____ / _____
mo. day yr.

SECTION B — AGENT STATEMENT

I have personally, completely and accurately reaffirmed the information supplied by the applicant(s).

Agent's Signature: **X** _____ Date Signed: _____ / _____ / _____
(mo.) day yr.

Print Your Name as You Signed It: _____ Agent's Phone Number: _____

Agent's Code: _____

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

CONSUMER MARKETS

® Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans
® Registered Service Mark of Health Care Service Corporation

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Health Care Service Corporation. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAS NEVER BEEN IN FORCE. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Note to Producer: An applicant who is replacing existing health insurance with Blue Cross and Blue Shield coverage must read, sign, and date the adjacent replacement form at right. You must then submit that replacement form along with the application. This half of the form must remain with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Health Care Service Corporation. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
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The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

□□□□ - □□ - □□□□□□

(Applicant's Social Security Number)

CUT HERE

CONDITIONAL RECEIPT FOR



BlueCross BlueShield
of Illinois

Proposed Insured: _____

Date of Application: _____ Amount Received: _____ Date of Receipt: _____

NO INSURANCE WILL BECOME EFFECTIVE UNLESS EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO PRODUCER IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.

Subject to the limitations shown below, insurance will become effective under the receipt if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Health Care Service Corporation, a Mutual Legal Reserve Company (Blue Cross and Blue Shield of Illinois), hereafter "HCSC," at its Home Office (or the office of the designated administrator).
2. The first full premium, according to the mode of premium payment chosen, has been paid and the check is honored on first presentation for payment.
"An effective date in compliance with HCSC guidelines" means the latter of:
 - a. The requested coverage date, if any, shown on the application; or
 - b. The date upon which the application is approved by HCSC at its Home Office (or office of the designated administrator).
3. The policy is issued by HCSC exactly as applied for within 60 days from date of application, delivered, and accepted by the proposed insured.

Applicant's Copy (if paying by check or money order)

(over, please)

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____ Check One: Checking Account Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED
--

Applicant's Copy (if paying by automatic bank withdrawal)

▲ CUT HERE ▲

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____ Check One: Checking Account Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED		
ADDRESS OF BANK		
CITY	STATE	ZIP
NAME OF INSURED, APPLICANT (PRINT)		
NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED		RELATIONSHIP TO INSURED
SIGNATURE OF DEPOSITOR		DATE

For Home Office Use Only:	BANK TRANSIT NUMBER	DEPOSITOR'S ACCOUNT NUMBER
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PLEASE ATTACH VOIDED CHECK OR DEPOSIT SLIP

Company's Copy (if applicant is paying by automatic bank withdrawal)

30443.0706 IL

Limitation:

This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided herein. In the event HCSC declines to issue a policy as applied for, the amount received by HCSC will be refunded.

Hugo Tagli Jr.

Signature of Secretary

Signature of Producer

Producer's Code: _____

Blue Cross and Blue Shield of Illinois
Administrator: Hallmark Services Corp.
PO Box 2038
Aurora, Illinois 60507-2038

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF ILLINOIS.
DO NOT PAY CASH OR MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

If you do not hear from HCSC regarding the proposed insurance within 30 days, please call 1-800-538-8833.

THIS FORM LIMITS OUR LIABILITY.

BE SURE TO READ AND SIGN THE APPLICATION AND, IF DESIRED, THE AUTOMATIC PAYMENT REQUEST FORM. KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.

CONSUMER MARKETS

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PRODUCER'S NEW BUSINESS CHECKLIST

For quick processing of all applications...

Use this simple checklist before submitting your applications to assure prompt processing.

Have you:

- Reviewed each application to verify that it is complete and legible?
- Assured that all the necessary signatures are provided?
- Assured that any changes to an application are initialed by the applicant?
- Attached detailed descriptions for any health questions which have been answered "YES"?
- Included your Agent Code and phone number on the application?
- Completed the "Conditional Receipt" form?
- Given the applicant a copy of the Outline of Coverage?

IMPORTANT!

Use this checklist to make sure you've completed all needed information.

In addition...

- There are NO C.O.D.s.
- The check for the exact amount should be made payable to: Blue Cross and Blue Shield of Illinois.

If applicant is paying by bank draft authorization, make sure the authorization form is completed, a voided check or deposit slip is attached, and a check for the first month's premium is submitted.

If applicant is selecting the two-month payment mode, a check for the first two months' premium should be submitted.
- If applicant is replacing his/her current coverage, make sure a signed replacement form is also attached.

**THIS SALES KIT PROVIDES
HEALTH INSURANCE PLAN
HIGHLIGHTS ONLY.**

When we receive your application, we will evaluate your medical history and, if approved, you will receive your ID card and policy.

Your coverage documents include a full description of benefits, limitations, exclusions and other features of coverage. You have 30 days to examine your coverage with no risk or obligation. We want you to be 100% satisfied. If you should change your mind about your Blue Cross and Blue Shield of Illinois policy, even after you've made your first premium payment, simply return your policy and membership card to your insurance representative within 30 days after the activation of the policy. If no claims were filed, you will get a refund of your premium. You'll be under no further obligation.