Plan 3 Benefit Summary

(Revised Effective January 1, 2015)

The Affordable Care Act ACA requires all individuals to enroll in health insurance coverage that includes a specific set of benefits and consumer protections. This type of health coverage is known as "minimal essential coverage." Individuals who do not have minimal essential coverage may be subject to the tax penalty at the time they file their federal income tax return unless they are otherwise exempt.

Pursuant to 45 CFR 156.604, the federal government has determined that the Illinois Comprehensive Health Insurance Plan (ICHIP) does not constitute minimal essential coverage for plan years that began January 1, 2015 or later. Therefore, if You enroll in the ICHIP plan for January 1, 2015, You may be subject to a tax penalty at the time You file Your tax return for 2015 and later years.

Your health care benefits for all Covered Services are outlined below. However, to fully understand Your benefits, it is very important that You read Your entire Benefit Plan Booklet, including any amendments thereto. Refer to the Schedule Page for specific information about the Deductible and other options which apply to Your CHIP Coverage. **All benefits described in this Benefit Summary are subject to all of the terms and conditions of Your Benefit Plan Booklet.**

The CHIP Plan You have qualified for contains a Preferred Provider Organization (PPO) benefit level and a Non-Preferred Provider Organization (Non-PPO) benefit level. This means that different benefit levels apply, depending on whether You use a PPO Provider or a Non-PPO Provider. To receive the maximum benefits allowed under Your CHIP coverage, always make sure that You use a PPO Provider. Visit the Plan Administrator's website at www.bcbsil.com or call 1-800-810-2583 (1-800-810-BLUE) to find out which Providers are in the PPO network, or check with Your Physician to see if he/she is a PPO Provider.

LIFETIME MAXIMUM BENEFIT	$5,000,000
DEDUCTIBLES $1,500, $2,500 or $5,000 per Calendar Year)	Your Individual and Family Deductible amounts depend on which option You selected and are specified on the Schedule Page
*** HOSPITAL ADMISSION DEDUCTIBLE (per admission, per individual in addition to Your calendar year deductible)**	For each admission to a PPO Hospital, $0 For each admission to a Non-PPO Hospital, $300
CO-INSURANCE	80/20 for Participating Providers up to Out-of-Pocket Expense Amount (60/40 if Non-PPO Providers are used)
OUT-OF-POCKET EXPENSE AMOUNT (does not apply to all services)	$2,500 Per Calendar Year **Plus** the Amount of the Calendar Year Deductible Option You Selected (for Yourself) or $5,000 Per Calendar Year **Plus** Two Times the Amount of the Calendar Year Deductible You Selected (for Your Family)
OUT-OF-NETWORK EXPENSE LIMIT (applies ONLY if Non-PPO Provider is used and is in addition to any Out-Of-Pocket Expense Amount applicable)	$5,500 Per Calendar Year **Plus** the Amount of the Calendar Year Deductible Option You Selected and any Additional Deductibles that apply (for Yourself) or $11,000 Per Calendar Year **Plus** Two Times the Amount of the Calendar Year Deductible You Selected and any Additional Deductibles that apply (for Your Family)
PREEXISTING CONDITION LIMITATION	6 months

BENEFIT PAYMENT LEVELS

Hospital Benefit

Hospital Admission Deductible (per admission, per individual in addition to Your calendar year deductible)	For each admission to a PPO Hospital, $0 For each admission to a Non-PPO Hospital, $300*
Inpatient (Illinois and Border Hospitals)	Provided Precertification Is Obtained, 80% of Eligible Charge for PPO Hospitals and 60% of Eligible Charge for Non-PPO Hospitals
Inpatient (Out of State Hospitals) For all Hospital Confinements More Than 75 Miles Outside the State of Illinois	Same as for Illinois and Border Hospitals, but Limited To a Combined Total of 45 Days per Calendar Year (Including Hospital Confinements for Mental Illness Treatment and Substance Abuse Rehabilitation Treatment Programs)
Outpatient	80% of the Eligible Charge for PPO Hospitals 60% of the Eligible Charge for Non-PPO Hospitals

Mental Illness Treatment and Substance Abuse Rehabilitation Treatment Program

Inpatient (Illinois Hospitals)	Provided Pre-Certification Is Obtained, 80% of Eligible Charge for PPO Hospitals, 60% of Eligible Charge for Non-PPO Hospitals
Inpatient (Out of State Hospitals)	Same as for Illinois Hospitals, but Limited to a Combined Total of 45 Days Per Calendar Year for All Hospital Confinements Outside the State of Illinois (See Hospital Benefit, above)
* Outpatient Limited to 50 visits Per Calendar Year	80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers

Physician Benefits

Surgical Services	80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers
Diagnostic Services	80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers
Other Professional Medical Services Including Office Visits	80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers

Skilled Nursing Facility Care Limited to 120 Days Per Calendar Year Pre-certification Required	80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers

Home Health Care Limited to 270 Visits Days Per Calendar Year Prior Approval Required	80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers
Hospice Care Program Limited to 180 Days Per Calendar Year Prior Approval Required	80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers
Specified Organ Or Tissue Transplant Benefit No benefits unless a Participating Transplant Center for the Specified Transplant Approved by CHIP is used and all applicable Benefit Plan requirements are satisfied	Provided Prior Approval is Obtained, a Participating Transplant Center is Used for the Specified Organ or Tissue Transplant Approved by CHIP, and all other benefit plan requirements are satisfied. Maximum is the Transplant Payment Allowance
Other Covered Services	
** Outpatient Prescription Drugs No Benefits Available unless the Prescription Drug Card Program is used – 30 day supply for retail, 90 day supply for mail order	70% of Eligible Charge (show Pharmacy Your CHIP ID card) provided a Participating Pharmacy Is Used and the Claim is submitted electronically to the Plan Administrator (30% Co-pay applies to all covered Outpatient prescriptions, subject to $10 minimum, $200 maximum for retail; $30 minimum, $600 maximum for mail order and a separate $4,000 maximum out-of-pocket per calendar year)
Ambulance Service	To Nearest Hospital Qualified to Treat Condition, 80% of Usual and Customary Fee
Physical, Speech and Functional Occupational Therapy	80% of Eligible Charge or Maximum Allowance for Participating Providers. 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers
Durable Medical Equipment	Provided Prior Approval is Obtained for Items Costing $500 or more, 80% of Usual and Customary Fee
*** Optional Maternity Coverage Benefits are not provided for Maternity services unless an optional Maternity Benefits Rider has been purchased.	**NOTE: The Optional Maternity Coverage Rider can only be purchased at time of application or within 60 days of the date of Your marriage.**

Dental care, vision care (except for cataracts), and hearing care are not covered. Refer to Part M, Exclusions – What is Not Covered, for a complete listing of non-covered items.

All Benefits are subject to Eligible Charges, Maximum Allowances, medical necessity, standards of practice, and all other terms, conditions, limitations and exclusions as described in the Benefit Plan Booklet for Plan 3 (Rev 01/15), and any amendments thereto.

* *Does not apply to Out-of-Pocket Expense Amount.*

** *Does not apply to Deductible. A separate Prescription Drug maximum out-of-pocket applies.*

*** Maternity Services are not covered, except for Complications of Pregnancy, unless You have purchased a separate Maternity Benefits Rider (Refer to Your Schedule Page).