



### SUMMARY OF BENEFITS <sup>6</sup> - HH40

	In-Network	Out-of Network <sup>1</sup>
<b>Annual Deductible</b>		
Employee Only Coverage	\$2,500	\$5,000
Employee with Dependent Coverage	\$5,000	\$10,000
<b>Co-Insurance</b>	100% after deductible	70% of Maximum Allowable Fee
<b>Maximum Out of Pocket</b>		
Employee Only Coverage (does not include deductible)	\$0	\$5,000
Employee with Dependent Coverage (does not include deductible)	\$0	\$10,000
<b>Facility Charges <sup>4</sup></b>		
Inpatient	100% after deductible	70% of Maximum Allowable Fee
Outpatient	100% after deductible	70% of Maximum Allowable Fee
X-Ray/Lab	100% after deductible	70% of Maximum Allowable Fee
<b>Emergency Care <sup>2</sup></b>		
Ambulance (\$2,500 calendar year maximum)	100% after deductible	100% of Maximum Allowable Fee
Emergency Room	100% after deductible	100% of Maximum Allowable Fee
<b>Physician Office Visit</b>	100% after deductible	70% of Maximum Allowable Fee
<b>Preventive Care</b> (\$500 calendar year maximum)	\$0 co-pay	No Coverage
<b>Serious Mental Health <sup>3,4</sup></b>		
Inpatient	100% after deductible	70% of Maximum Allowable Fee
Inpatient Days per calendar year	45 total days (In and Out of Network)	
Outpatient	100% after deductible	70% of Maximum Allowable Fee
Outpatient Visits per calendar year	60 total visits (In and Out of Network)	
<b>Non-Serious Mental Health</b> (\$10,000/Yr Max)		
Inpatient	100% after deductible	70% of Maximum Allowable Fee
Inpatient Days per calendar year	35 total days (In and Out of Network)	
Outpatient	100% after deductible	70% of Maximum Allowable Fee
Outpatient Visits per calendar year	35 total visits (In and Out of Network)	
<b>Home Health Care <sup>4</sup></b>	100% after deductible	70% of Maximum Allowable Fee
Visits per calendar year	50 total visits (In and Out of Network)	
<b>Skilled Nursing Facility <sup>4</sup></b>	100% after deductible	70% of Maximum Allowable Fee
Days per calendar year	15 total days (In and Out of Network)	
<b>Other Services</b>		
<b>Manipulative Therapy</b> (\$100/visit to a \$1,000 calendar year maximum)	100% after deductible	70% of Maximum Allowable Fee
<b>Durable Medical Equipment</b> (\$5,000/yr maximum) <sup>4</sup>	100% after deductible	70% of Maximum Allowable Fee
<b>Transplants</b> (\$300,000 Lifetime maximum) <sup>4</sup>	100% after deductible	No Coverage
<b>Prescription Drug Rider -Retail <sup>5</sup></b>	<b>Subject to deductible then \$15/\$35/\$50</b>	
<b>Prescription Drug Rider -Mail Order</b> (90 day supply) <sup>5</sup>	<b>Subject to deductible then \$30/\$70/\$100</b>	
<b>Lifetime Maximum Benefit</b>	\$2,000,000	
<b>Notes</b>		
To be covered, expenses must be medically necessary. More information on medical necessity can be found in the Certificate of Insurance booklet.		
<sup>1</sup> Out of Network Charges subject to Maximum Allowable Fee. Refer to Certificate of Insurance for details.		
<sup>2</sup> Includes sickness or bodily injury which is life threatening or will significantly worsen without immediate medical or surgical treatment.		
<sup>3</sup> No coverage for groups below 51 employees for Serious Mental Health, as per Illinois statute.		
<sup>4</sup> Pre-certification is needed to receive these benefits. Failure to obtain pre-certification may result in reduced benefits.		
<sup>5</sup> When a generic is available, but the pharmacy dispenses the brand name for any reason, you will pay the difference between the brand name drug and the generic plus the generic copayment. After the first retail pharmacy refill, medications must be refilled through mail order. "Specialty" drugs are limited to a 30 day supply.		
<sup>6</sup> This is a summary only. The Certificate of Insurance determines benefits provided.		