



SUMMARY OF BENEFITS ⁶ - PG40

| | In-Network | Out-of Network ¹ |
|---|---|--|
| Annual Deductible | | |
| Individual | \$1,000 | \$2,000 |
| Family | \$3,000 | \$6,000 |
| Co-Insurance | 90% | 70% of Maximum Allowable Fee |
| Maximum Out of Pocket | | |
| Individual (does not include deductible) | \$1,500 | \$4,500 |
| Family (does not include deductible) | \$4,500 | \$13,500 |
| Facility Charges ⁴ | | |
| Inpatient | 90% | 70% of Maximum Allowable Fee |
| Outpatient | 90% | 70% of Maximum Allowable Fee |
| X-Ray/Lab | 90% | 70% of Maximum Allowable Fee |
| Emergency Care ² | | |
| Ambulance (\$2,500 calendar year maximum) | 80% | 80% of Maximum Allowable Fee |
| Emergency Room | \$100 co-pay | \$100 co-pay Subject to Maximum Allowable Fee |
| Physician Office Visit | \$25 co-pay | 70% of Maximum Allowable Fee |
| Preventive Care (\$500 calendar year maximum) | \$0 co-pay | No Coverage |
| Serious Mental Health ^{3,4} | | |
| Inpatient | 90% | 70% of Maximum Allowable Fee |
| Inpatient Days per calendar year | 45 total days (In and Out of Network) | |
| Outpatient | 90% | 70% of Maximum Allowable Fee |
| Outpatient Visits per calendar year | 60 total visits (In and Out of Network) | |
| Non-Serious Mental Health (\$10,000/Yr Max) | | |
| Inpatient | 90% | 70% of Maximum Allowable Fee |
| Inpatient Days per calendar year | 35 total days (In and Out of Network) | |
| Outpatient | 90% | 70% of Maximum Allowable Fee |
| Outpatient Visits per calendar year | 35 total visits (In and Out of Network) | |
| Home Health Care ⁴ | 90% | 70% of Maximum Allowable Fee |
| Visits per calendar year | 50 total visits (In and Out of Network) | |
| Skilled Nursing Facility ⁴ | 90% | 70% of Maximum Allowable Fee |
| Days per calendar year | 15 total days (In and Out of Network) | |
| Other Services | | |
| Manipulative Therapy (\$100/visit to a \$1,000 calendar year maximum) | \$30 co-pay | 70% of Maximum Allowable Fee |
| Durable Medical Equipment (\$5,000/yr maximum) ⁴ | 80% | 80% of Maximum Allowable Fee |
| Transplants (\$300,000 Lifetime maximum) ⁴ | 90% | No Coverage |
| Prescription Drug Rider -Retail ⁵ | See Attached | |
| Prescription Drug Rider -Mail Order (90 day supply) ⁵ | See Attached | |
| Lifetime Maximum Benefit | \$2,000,000 | |
| Notes | | |

To be covered, expenses must be medically necessary. More information on medical necessity can be found in the Certificate of Insurance booklet.

¹ Out of Network Charges subject to Maximum Allowable Fee. Refer to Certificate of Insurance for details.

² Includes sickness or bodily injury which is life threatening or will significantly worsen without immediate medical or surgical treatment.

³ No coverage for groups below 51 employees for Serious Mental Health, as per Illinois statute.

⁴ Pre-certification is needed to receive these benefits. Failure to obtain pre-certification may result in reduced benefits.

⁵ 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.

⁶ This is a summary only. The Certificate of Insurance determines benefits provided.