



**SUMMARY OF BENEFITS <sup>6</sup> - SO40**

	<b>In-Network</b>	<b>Out-of Network <sup>1</sup></b>
<b>Annual Deductible</b>		
Individual	\$0	\$1,500
Family	\$0	\$4,500
<b>Co-Insurance</b>	100%	50% of Maximum Allowable Fee
<b>Maximum Out of Pocket</b>		
Individual (does not include deductible)	\$0	\$4,500
Family (does not include deductible)	\$0	\$13,500
<b>Facility Charges <sup>4</sup></b>		
Inpatient Copay per admission	\$250	50% of Maximum Allowable Fee
Outpatient Copay	\$50/visit	50% of Maximum Allowable Fee
<b>Emergency Care <sup>2</sup></b>		
Ambulance (\$2,500 calendar year maximum)	\$100	\$100 Subject to Maximum Allowable Fee
Emergency Room Copay	\$100	\$100 Subject to Maximum Allowable Fee
<b>Physician Office Visit</b>	\$20	50% 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 Copay per admission	\$250	50% of Maximum Allowable Fee
Inpatient Days per calendar year	45 total days (In and Out of Network)	
Outpatient	\$100 co-pay	50% 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 Copay per admission	\$250	50% of Maximum Allowable Fee
Inpatient Days per calendar year	35 total days (In and Out of Network)	
Outpatient	\$100 co-pay	50% 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 co-pay	50% 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 co-pay	50% 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)	\$25 co-pay	50% of Maximum Allowable Fee
<b>Durable Medical Equipment</b> (\$5,000/yr maximum) <sup>4</sup>	\$100 co-pay	50% of Maximum Allowable Fee
<b>Transplants</b> (\$300,000 Lifetime maximum) <sup>4</sup>	\$100 co-pay	No Coverage
<b>Prescription Drug Rider -Retail <sup>5</sup></b>	<b>See Attached</b>	
<b>Prescription Drug Rider -Mail Order</b> (90 day supply) <sup>5</sup>	<b>See Attached</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.