ILLINOIS EDUCATORS RISK MANAGEMENT PROGRAM – POS-C + 2000

SCHEDULE OF BENEFITS

Lifetime Maximum Benefits	**Preferred Provider/ Non-Preferred Provider**
Individual Lifetime Maximum Benefit	Unlimited
Temporomandibular Joint (TMJ) Disorder	$2,500 per member

The term "Lifetime" refers to the time a person is actually a Beneficiary of a welfare benefit plan sponsored by the Group and is not intended to suggest benefits beyond an individual's termination date.

Plan Year Maximum Benefits	
Inpatient Rehabilitation and Skilled Nursing Care	120 days
Outpatient Rehabilitative Therapy Services (Occupational, speech and physical therapies)	60 visits (treatment combined)
Cardiac Rehabilitation	36 sessions within 6 months of event
Spinal Manipulations	$500 per member

The maximum benefits allowed for Preferred and Non-Preferred services are combined.

Plan Year Deductibles	**Preferred Provider**	**Non-Preferred Provider**
Single	$750	$5,000
Family	$1500	$10,000

Deductibles apply to all covered services except Emergency Room Visits, Ambulance, and Spinal Manipulations. A new Deductible will apply each Plan Year. Family deductible is cumulative for all family members combined.

Plan Year Out-of-Pocket Maximum	**Preferred Provider**	**Non-Preferred Provider**
Single	$4,750	$10,000
Family	$9,500	$20,000

All Deductibles, Copays and Coinsurance apply to the Out-of-Pocket Maximum. Charges over the Usual, Customary and Reasonable (UCR) and Non-Covered Services do not apply to the Out-of-Pocket Maximum.
Family Out-of-Pocket Maximum is cumulative for all family members combined.

Preauthorization Penalty	**Preferred Provider/ Non-Preferred Provider**	
Failure to Preauthorize	Not applicable	Not Applicable

NOTES:

Inpatient Services/Benefits	You Pay Preferred Provider	You Pay Non-Preferred Provider
Physician Services	20% coinsurance	50% coinsurance
Hospital Care	$2,000 copay per admission then 20% coinsurance	50% coinsurance
Inpatient Rehabilitation and Skilled Nursing Care	20% coinsurance	50% coinsurance
Human Organ Transplant	20% coinsurance	Not Covered
Mental Health Care	$2,000 copay per admission then 20% coinsurance	50% coinsurance
Substance Abuse Treatment	$2,000 copay per admission then 20% coinsurance	50% coinsurance

Outpatient Services/Benefits		
Office Visit-Primary Care	$25 copay	50% coinsurance
Office Visit-Specialty Care	$50 copay	50% coinsurance
Routine Prenatal Care	20% coinsurance	50% coinsurance
Be Healthy Wellness Benefit Program: Annual Physicals, Injections, Immunizations, Mammograms, PAP Smears, Prostate Screening, Colorectal Screening, Cholesterol Screening	0% coinsurance	50% coinsurance
Well Child Care	0% coinsurance	50% coinsurance
Routine Eye Exams (Adult)	$40 copay	Not Covered
Routine Eye Exams (Pediatric)	$40 copay	Not Covered
Outpatient Surgery	$2,000 copay per procedure then 20% coinsurance	50% coinsurance
Diagnostic Testing (X-rays and laboratory services)	20% coinsurance	50% coinsurance
Imaging (CT/PET scans, MRIs)	$1,000 copay per procedure then 20% coinsurance	50% coinsurance
Mental Health Care	$25 copay	50% coinsurance
Substance Abuse Treatment	$25 copay	50% coinsurance
Home Health Care/Home Infusion	20% coinsurance	50% coinsurance
Hospice Care	20% coinsurance	50% coinsurance

NOTES:

Outpatient Services/Benefits	You Pay Preferred Provider	You Pay Non-Preferred Provider
Rehabilitative Therapy Services (Occupational, speech and physical therapies)	20% coinsurance	50% coinsurance
Emergency Services (copay waived if admitted)	$200 copay	$200 copay
Ambulance Services (must be medically necessary)	$100 copay	$100 copay
Urgent Care	$50 copay	50% coinsurance
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	50% coinsurance
TMJ Disorder	20% coinsurance	50% coinsurance
Spinal Manipulations	50% coinsurance	50% coinsurance
Retail Prescription Drugs (Limited to a maximum 30-day supply)	$10 Tier 1 $40 Tier 2 $80 Tier 3	50% coinsurance
Mail-Order Prescription Drugs (Limited to a maximum 90-day supply)	$27.50 Tier 1 $110 Tier 2 $220 Tier 3	50% coinsurance
Infertility Services	Office Visit/Hospital Copay/Coinsurance Applies	Office Visit/Hospital Coinsurance Applies
Specialty Prescription Drugs	50% Tier 4 50% Tier 5 50% Tier 6	50% coinsurance
Other Covered Services	20% coinsurance	50% coinsurance

NOTES:

Your Non-Preferred Provider Coinsurance is based on Usual, Customary and Reasonable (UCR) fees. In addition to the Coinsurance, you also pay any charges in excess of the UCR amount.

Preferred Provider Coinsurance, if any, is based on the allowed or discounted amount.