ILLINOIS EDUCATORS RISK MANAGEMENT PROGRAM – HMO 80 Plan

SCHEDULE OF BENEFITS

1/1/2021

Lifetime Maximum Benefits	**Preferred Provider/ Non-Preferred Provider**
Individual Lifetime Maximum Benefit	Unlimited

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	
Outpatient Rehabilitative Therapy Services (Occupational, speech and physical therapies)	60 visits (treatment combined)
Vision Exam (Adult)	1 exam every 12 months
Acupuncture Treatment	15 visits

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

Plan Year Deductibles	**Preferred Provider**	**Non-Preferred Provider**
Single	$0	Not Applicable
Family	$0	Not Applicable

Plan Year Out-of-Pocket Maximum	**Preferred Provider**	**Non-Preferred Provider**
Single	$2,000	Not Applicable
Family	$4,000	Not Applicable

All Copays and Coinsurance apply to the Out-of-Pocket Maximum. 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	Not Covered
Hospital Care	20% coinsurance	Not Covered
Inpatient Rehabilitation and Skilled Nursing Care	20% coinsurance	Not Covered
Human Organ Transplant	20% coinsurance	Not Covered
Mental Health Care	20% coinsurance	Not Covered
Substance Abuse Treatment	20% coinsurance	Not Covered

Outpatient Services/Benefits		
Office Visit-Primary Care	$25 copay	Not Covered
Office Visit-Specialty Care	$50 copay	Not Covered
Acupuncture Services	$25 copay	Not Covered
Routine Prenatal Care	20% coinsurance	Not Covered
Be Healthy Wellness Benefit Program	0% coinsurance	Not Covered
Well Child Care	0% coinsurance	Not Covered
Routine Eye Exams (Adult)	$40 copay	Not Covered
Routine Eye Exams (Pediatric)	Not Covered	Not Covered
Outpatient Surgery	20% coinsurance	Not Covered
Diagnostic Testing (X-rays and laboratory services)	20% coinsurance	Not Covered
Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered
Mental Health Care	$25 copay	Not Covered
Substance Abuse Treatment	$25 copay	Not Covered
Home Health Care/Home Infusion	Not Covered	Not Covered
Hospice Care	20% coinsurance	Not Covered

NOTES:

Outpatient Services/Benefits	You Pay Preferred Provider	You Pay Non-Preferred Provider
Rehabilitative Therapy Services (Occupational, speech and physical therapies)	20% coinsurance	Not Covered
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 copay
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	Not Covered
TMJ Disorder	Not Covered	Not Covered
Spinal Manipulations	$20 copay	Not Covered
Infertility Services	Not Covered	Not Covered
Other Covered Services	20% coinsurance	Not Covered

Pharmacy- Carved-Out through CVS Caremark		
Retail Prescription Drugs (Limited to a maximum 30-day supply)	$20 Tier 1 $40 Tier 2 $80 Tier 3	Not Covered
Mail-Order Prescription Drugs (Limited to a maximum 90-day supply)	$55 Tier 1 $110 Tier 2 $220 Tier 3	Not Covered
Specialty Prescription Drugs	20% Tier 4 20% Tier 5 20% Tier 6	Not Covered

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.

CVS contact information:
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