DEKALB CUSD #428 – PLAN 2

	PPO PLUS	
Lifetime Comprehensive Major Medical Coverage:	**$1,000,000**	
	PPO Coverage	**Non-PPO Coverage**
Deductible: (per individual per calendar year)	$1,500	
Family Deductible: A maximum of two individual deductibles	$3000	
Out-of-Pocket Expense Limitation: The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, **excluding the deductible.** Non-PPO charges apply toward a separate out-of-pocket limit. Elective MSA copayment, charges in excess of the Schedule of Maximum Allowances and items asterisked (*) below do not apply to any out-of-pocket limit.	$2,000 Individual $4,000 Family	$2,500 Individual $5,000 Family
Inpatient Hospital Services: Room allowance based on the hospital's most common semi-private rate. Pre-Admission Testing, Skilled Nursing Facility and Coordinated Home Care are paid on the same basis. **Deductible per Admission:**	90% -	70% $300
Outpatient Surgery & Diagnostic Tests:	90%	70%
Other Outpatient Hospital: (Radiation Therapy, Chemotherapy, etc.)	90%	70%
Outpatient Emergency: (Hospital & Physician) Emergency Medical and Emergency Accident - initial treatment in hospital or physician's office of accidental injuries or sudden and unexpected medical conditions with severe life-threatening symptoms. Payments are based on schedule of maximum allowances.	100%**	100%**
Inpatient Mental and Substance Abuse: Inpatient care limited to 30 visits per calendar year.	80%*	60%*
Outpatient Mental and Substance Abuse: Outpatient care limited to 50 visits per calendar year.	60%*	50%* $50 Max. per visit
Serious Mental Illness Service: Inpatient care limited to 45 days per calendar year. Outpatient care limited to 35 days per calendar year.	90%	70%
Medical Surgical Care: Payments are based on the Schedule of Maximum Allowances. PPO providers have agreed to accept the Schedule of Maximum Allowances as payment in full for covered services excluding your deductible and any coinsurance. Non-PPO providers do not accept the Schedule of Maximum Allowances as payment in full. You will be liable for any difference between the physician's charge and our payment.	90%	70%
Physician Office Visits: Copay applicable to the office visit charge only.	100%* $20 Copay*	70%
Well Care: (all ages) Including physical exams, immunizations. Colonoscopy covered at 100%. Care limited to $500 per calendar year.	90%**	70%**
Chiropractic Services: Care limited to $1,000 per calendar year.	90%*	70%*
Therapy: Services of a registered professional physical, occupational and speech therapist. $5,000 per cal. Yr.	90%	70%
Other Covered Services: Blood and blood components; leg, arm, back and neck braces, Temporomandibular Joint Dysfunction ($2,500* Lifetime Maximum); private duty nursing ($1,000* per month maximum); ambulance services; allergy shots; oxygen and its administration; surgical dressings, casts, and splints; durable medical equipment; prosthetic devices.	90%*	
Prescription Drugs: Prescription Drug benefit paid at 100% after coinsurance at participating pharmacy. #Drugs purchased at a non-participating pharmacy are paid at 75% of amount after coinsurance.	20%, $10 Minimum. See notes#	
Mail Order prescription maintenance drugs paid at 100% after copayment. Provides up to a 90-day supply of maintenance drugs used on a continuous basis for treatment of chronic health conditions.	$15 copay* Generic $25 copay* Formulary $45 copay* Non-Formulary	
Infertility: State Mandated Benefits (std.)		
Hospice: Covered with no inside maximum (std.)		
Transplant Coverage: Cornea, kidney, bone marrow, heart valve, muscular-skeletal or parathyroid human organ tissue. In addition heart, lung, heart/lung, liver, pancreas and pancreas/kidney are covered under certain circumstances when performed in an approved facility and with Medical Director approval.		

BASIC PROVISIONS

Medical Services Advisory: Notification required prior to all elective admissions. Emergency and Obstetric Admission Notification required within two working days of admittance. **IF EMPLOYEE ELECTS NOT TO NOTIFY MSA ADVISOR OR FOLLOW ADVICE GIVEN, HOSPITAL BENEFITS REDUCED BY $1,000.**

Pre-Existing Conditions Waiting Period: There is a 365 day waiting period, waived for new groups if replacing other coverage.

Dependent Eligibility: To age 19, or 25 if full time student.

Coordination of Benefits: This program coordinates benefits with other group plans.

* Copayments do not apply to any out-of-pocket expense limitation. Coinsurance amount except as otherwise so noted, apply to the PPO Out-of-pocket Expense Limitation.

** Deductible does not apply.

In addition to benefits stated herein, benefits for covered persons who reside outside of Illinois will conform to all extraterritorial requirements of those states.