

Summary of Benefits		
STL-002		
<p><i>This Summary of Benefits is intended to give an <u>overview</u> of the Plan benefits. In the event that this summary and the Certificate of Coverage differ, the Certificate of Coverage or the associated benefit Riders will govern.</i></p> <p style="text-align: center;"><i><u>Authorization may be required</u> - see the Certificate of Coverage for more information.</i></p> <p style="text-align: center;"><i><u>Limitations may exist for some benefits</u> - see the Certificate of Coverage for more information.</i></p>		
	Network	Non-Network
Annual Deductible <i>Note: this is a Calendar Year Deductible</i>	\$500 per Covered Person Maximum for all \$1,500 Covered Persons in a family	\$1,000 per Covered Person Maximum for all \$3,000 Covered Persons in a family
Out-of-Pocket Maximum <i>Note: the Out-of-Pocket Maximum does not include the Annual Deductible.</i>	\$0 per Covered Person Maximum for all \$0 Covered Persons in a family	\$3,000 per Covered Person Maximum for all \$9,000 Covered Persons in a family
Maximum Policy Benefit	No Maximum Policy Benefit per Covered Person	\$5,000,000 per Covered Person
Services	Network	Non-Network <i>Benefits subject to UCR limits</i>
Physician's Office Services	\$20 Copayment to a PCP	30% After Deductible
	\$40 Copayment to a Specialist	30% After Deductible
Laboratory Services	\$0 Copayment	30% After Deductible
X-ray or Other Diagnostic	0% After Deductible	30% After Deductible
Outpatient Surgery	0% After Deductible	30% After Deductible
Preventive Health & Wellness Services <i>Cholesterol test, Colonoscopy, Double-contrast Barium Enema, Fecal Occult Blood Test, Flexible Sigmoidoscopy, Pap/Pelvic, Mammography, Prostate exam, PSA test</i>	<i>(Note: office visit copayment will be charged where applicable)</i> 0% no Deductible when provided In-Mercy Network Only	30% After Deductible
Urgent Care Center Services	\$50 Copayment	\$100 Copayment
Emergency Health Services <i>Note: copayment is waived if admitted to Inpatient Hospital Stay</i>	\$100 Copayment	\$100 Copayment
Observation	0% After Deductible	30% After Deductible
Inpatient Hospital Stay <i>Note: semi-private room covered</i>	0% After Deductible	30% After Deductible
Outpatient Prescription Drug	Mandatory Generic Substitution No Annual Drug Deductible	
Tier One	\$12 Copayment	50% Coinsurance
Tier Two	\$35 Copayment	50% Coinsurance
Tier Three	\$60 Copayment	50% Coinsurance
Tier Four	20% up to \$100 Copayment	50% Coinsurance
Smoking Cessation Product	Up to three (3) months of coverage for certain smoking cessation products.	Not Covered
Mail Order	2 x Copayment	Not Covered

Services	Network	Non-Network <i>Benefits subject to UCR limits</i>
Allergy Injections/Treatment	0% <i>After Deductible</i>	30% <i>After Deductible</i>
Eye Examinations <i>(One routine exam per Calendar Year)</i>	\$40 <i>Copayment</i>	30% <i>After Deductible</i>
Chiropractic Care <i>(26 visits per Calendar Year)</i>	\$40 <i>Copayment</i>	Covered In-Mercy Network Only
Outpatient Therapy <i>(20 visits per Calendar Year for Physical, Speech or Occupational, 36 visits per Calendar Year for Pulmonary or Cardiac)</i>	0% <i>Coinsurance After Deductible</i>	30% <i>After Deductible</i>
Maternity Services Office Visit Outpatient Lab X-ray Inpatient Medical/ Observation	\$40 <i>Copayment (for initial visit only)</i> \$0 <i>Copayment</i> 0% <i>Coinsurance After Deductible</i> 0% <i>Coinsurance After Deductible</i>	30% <i>After Deductible</i>
Mental Health Services Outpatient Visit <i>(90 visits per Calendar Year)</i> Residential Treatment <i>(60 days per Calendar Year)</i> Inpatient Treatment	\$40 <i>Copayment</i> 0% <i>After Deductible</i> 0% <i>After Deductible</i>	30% <i>After Deductible</i> 30% <i>After Deductible</i> 30% <i>After Deductible</i>
Alcoholism & Chemical Dependency Services Outpatient Visit <i>(26 days per Calendar Year)</i> Residential Treatment <i>(21 days per Calendar Year)</i> Inpatient Detoxification <i>(Six days per Calendar Year)</i>	\$40 <i>Copayment</i> 0% <i>After Deductible</i> 0% <i>After Deductible</i>	30% <i>After Deductible</i> 30% <i>After Deductible</i> 30% <i>After Deductible</i>
Durable Medical Equipment <i>(\$5,000 limit per Calendar Year)</i>	0% <i>After Deductible</i>	30% <i>After Deductible</i>
Prosthetic Devices <i>(\$5,000 limit per Calendar Year)</i>	0% <i>After Deductible</i>	30% <i>After Deductible</i>
Home Health care <i>(60 visits per Calendar Year)</i>	0% <i>After Deductible</i>	30% <i>After Deductible</i>
Hospice Care <i>(180 days per lifetime)</i>	0% <i>After Deductible</i>	30% <i>After Deductible</i>
Transplantation Services <i>(Non-Network limit \$30,000 per transplant)</i>	0% <i>After Deductible</i>	30% <i>After Deductible</i>
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services <i>(60 days per Calendar Year)</i>	0% <i>After Deductible</i>	30% <i>After Deductible</i>
Injectables/ Infusions	0% <i>After Deductible</i>	30% <i>After Deductible</i>
Smoking Cessation	\$25 per program	Covered In-Mercy Network Only
Birth Control Services	Copay based on service	Copay based on service
Family Services <i>(Tubal Ligations & Vasectomies)</i>	Copay based on service	Copay based on service