DEPAUL UNIVERSITY
OFFICE OF HUMAN RESOURCES

HMO Illinois – Schedule of Benefits

LIFETIME COMPREHENSIVE MAJOR MEDICAL COVERAGE: Total lifetime maximum.	**Unlimited**	
	In-Network	**Out-of-Network**
DEDUCTIBLE: Per calendar year.	N/A	N/A
OUT-OF-POCKET EXPENSE LIMITATION: The amount of money an individual pays toward covered medical expenses during any one calendar year. Excludes prescription and Vision co-pays.	$1,500 / Individual $3,000 / Family	N/A
PRIMARY CARE PHYSICIAN (PCP) REQUIRED: PCP must coordinate or approve care.	Yes	N/A
WELLNESS CARE: Includes all wellness benefits; physicals, immunizations, routine sigmoidoscopy, colonoscopy, routine x-ray and lab; routine mammograms, pap smears, prostate exams, digital rectal exams, and colorectal cancer screenings. No benefit maximum.	100%	Not covered
HOSPITAL SERVICES: Including Inpatient services, home care, skilled nursing facility, hospice care, and Outpatient surgery (hospital and physician charges).	100% after $250 Hospitalization Co-pay	Not covered
INPATIENT SERVICES • **INPATIENT MENTAL HEALTH AND CHEMICAL DEPENDENCY/SUBSTANCE ABUSE:** Paid the same as any other inpatient admission.	100%	Not covered
OUTPATIENT SERVICES • **OUTPATIENT MENTAL HEALTH AND CHEMICAL DEPENDENCY/SUBSTANCE ABUSE:** Paid the same as any other outpatient condition.	100% after $30 Co-pay	Not covered
• **OUTPATIENT REHABILITATION SERVICES:** Includes physical, occupational, or speech therapy. Limit of 60 visits combined per calendar year. • **OUTPATIENT SPEECH THERAPY** • **OUTPATIENT SURGICAL SERVICES**	100% after $50 Co-pay	Not covered
PHYSICIAN MEDICAL/SURGICAL CARE: Includes medical and surgical care, anesthetics, etc.	100% after $50 Co-pay	Not covered
DOCTOR'S OFFICE VISITS: Includes specialist visits and medical services provided in a doctor's or specialist's office. No co-pay applies if no physician charge assessed. For maternity services, the $20 co-pay only applies to the first visit.	$30 Co-pay for primary care $50 Co-pay for specialist	Not Covered
INFERTILITY: Some services may be subject to coverage restrictions.	100% after $50 Co-pay	Not covered
EMERGENCY: (Hospital) Emergency Medical and Emergency Accident - Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions following the standard emergency criteria.	100% after $75 Co-pay (waived if admitted)	100% after $75 Co-pay (waived if admitted)
OTHER COVERED SERVICES: Ambulance services; surgical dressings, casts and splints; durable medical equipment; prosthetic devices; hospice.	100%	Not covered (except ambulance services)
PRESCRIPTION DRUGS: Benefits are available for drugs purchased from a participating pharmacy or professional provider (retail) or through the home delivery program. Benefits for retail drugs are provided for up to a maximum of a 34 consecutive day supply. Mail order provides up to a 90 day supply of maintenance drugs. 90 day supply also available at select Retail Stores.	Retail: generic: 80% ($10 min, $100 max) formulary: 70% ($10 min, $125 max) non-formulary: 65% ($10 min, $150 max); Mail Order Co-Pay: $25 generic $60 formulary $100 non-formulary	Not covered
VISION CARE: Exams covered once every 12 months. Eyewear allowance of $75 every 24 months, plus discounts. Member pays the remainder of eyewear cost after the discount.	100% for eye exam, $125 allowance for glasses/contacts	Not covered