Your Summary of Benefits

University of Southern Indiana - Core Plan
Blue Access® (PPO)
Effective January 1, 2020

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$750/$1,500	$1,500/$3,000
Out-of-Pocket Limit (Single/Family)	$4,500/$9,000	$9,000/$18,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products LiveHealth Online	 $30 $30 Covered in full Covered in full Covered in full $15	 40% 40% 40% 40% 40% 40%
Preventive Care Services Services included but not limited to: • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening	 No copayment/coinsurance	 40%
Emergency and Urgent Care Emergency Room Services • facility/other covered services (copayment waived if admitted) Urgent Care Center Services • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products • Allergy injections • Allergy testing	 $250 $75 20% Covered in full Covered in full	 $250 40% 40% 40% 40%
Inpatient and Outpatient Professional Services Include, but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	20%	40%
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Inpatient Facility Services (Network/Non-Network combined) Unlimited days including: • Unlimited days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • Unlimited days for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services (including but not limited to): • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services (Network/Non-Network combined) Unlimited visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% No copayment/coinsurance No copayment/coinsurance	40% No copayment/coinsurance No copayment/coinsurance
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 60 visits • Occupational therapy: 60 visits • Manipulation therapy: 12 visits • Speech therapy: 40 visits • Cardiac/Pulmonary Rehabilitation: Unlimited	 $30/$30 20% $30/$30 $30/$30 $30/$30 $30/$30 Copayments/Coinsurance based on setting where covered services are received	 40% 40% 40% 40% 40% 40% 40%
Accidental Dental: Unlimited	Copayments/Coinsurance based on setting where covered services are received	40%

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Behavioral Health Services Mental Illness and Substance Abuse[1]: • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • LiveHealth Online • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 20% 20% $30/$30 $15 20%	 40% 40% 40% 40% 40%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	No copayment/coinsurance	50%
Lifetime Maximum Medical Surgical Treatment of Morbid Obesity	 Unlimited Unlimited	 Unlimited Unlimited

Notes:

- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Dependent age: to end of the month which the child attains age 26.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan..
- NCS (No Cost Share) means no deductible/copayment/coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Benefit period = calendar year
- Prosthetic limbs are unlimited.
- Mammograms (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are no deductible/coinsurance up to the maximum allowable amount.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Wigs limited to 1 per benefit period

1 We encourage you to review the Schedule of Benefits for limitations.
2 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: None

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

This benefit overview is for illustrative purposes and some content may be pending Indiana Department of Insurance approval

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Signature:_____ Date:_____