Your Summary of Benefits



University of Southern Indiana Blue Access Health Savings Accounts Effective January 1, 2020

Covered Benefits	Network	Non-Network
Embedded Deductible		
The single deductible does apply to family coverage. Network	Single: \$2, 8 00	
and Non-Network deductibles are combined.	Family: \$5,600	
Out-of-Pocket Limit	Single: \$5,000	Single: \$10,000
	Family: \$10,000	Family: \$20,000
Physician Home and Office Services (PCP/SCP)	20%	40%
Primary Care Physician (PCP)/ Specialty Care		
Physician (SCP)		
LiveHealth Online	20%	40%
 Including Office Surgeries, allergy serum, 	20%	40%
allergy injections and allergy testing		
Preventive Care Services	No copayment/coinsurance	40%
Services include but are not limited to:		
Routine Exams, Mammograms, Pelvic Exams, Pap		
testing, PSA tests, Immunizations, Annual diabetic eye		
exam, Routine Vision and Hearing exams		
 Physician Home and Office Visits 		
Other Outpatient Services @		
Hospital/Alternative Care Facility		
Emergency and Urgent Care		
• Emergency Room Services @ Hospital	20%	20%
(facility/other covered services)		
Urgent Care Center Services	20%	40%
Inpatient and Outpatient Professional Services	20%	40%
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		
Inpatient Facility Services (Network/Non-Network	20%	40%
combined) Unlimited days except for:		
60 days for physical medicine/rehab		
(limit includes Day Rehabilitation Therapy		
Services on an outpatient basis)		
• 100 days for skilled nursing facility	2004	100/
Outpatient Surgery Hospital/Alternative Care Facility	20%	40%
Surgery and administration of general anesthesia		
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Other Outpatient Services (including but not limited to): O Non Surgical Outpatient Services For example: MRIS, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. O Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy) Durable Medical Equipment and Orthotics (excluding Prosthetic Devices and Medical Supplies) Prosthetic Devices Physical Medicine Therapy Day Rehabilitation programs Hospice Care 20% 20% 20% Accidental Bental Services \$3,000 limit per occurrence (network and non-network combined) 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: O cardiac Rehabilitation: 20 visits Physical therapy: 20 visits Physical therapy: 20 visits Speech therapy: 20 visits Speec	Covered Benefits	Network	Non-Network
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and storage.	and storage.		
Lifetime Maximum Unlimited Unlimited			
Surgical Treatment of Morbid Obesity Unlimited Unlimited	Surgical Treatment of Morbid Obesity	Unlimited	Unlimited

Your Summary of Benefits

Notes:

- All medical and drug cost shares, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance, including 0%.
- Deductible applies to all prescription drug expenses for Rx plans. Once the deductible is met the appropriate copayment/ coinsurance applies. Copayments/coinsurance accumulate to the Medical OOP max. Once the Medical OOP max is met, no additional cost share applies.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required before the family out-of-pocket is satisfied. Does not apply to embedded deductible plans.
- Network and Non-network Deductible, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each
 other.
- Dependent Age: to end of the month h which the child attains age 26
- 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- Live Health Online (LHO) is covered at the PCP cost share.
- Benefit period = calendar year
- 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 covered.
- 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 contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

Precertification:

Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period: None

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.

The benefits reflected in this quotation have been adjusted to comply with changes required by the Affordable Care Act beginning in 2014.

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

Signature:	Date:
6	