Your Summary of Benefits

Southeastern Indiana School Insurance Consortium – PPO Plan
Blue Access® PPO
Effective: January 1, 2018

Covered Benefits	Network	Non-Network
Deductible	Single: $1,500 Family: $3,000	Single: $3,000 Family: $6,000
Out-of-Pocket Limit	Single: $2,500 Family: $5,000	Single: $5,000 Family: $10,000
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	$50/$50 PCP/SCP	50%
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	NCS	50%
Emergency and Urgent Care • Emergency Room Services (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services	$250 copay $75 copay	$250 copay 50%
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%	50%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days for skilled nursing facility	20%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	50%
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Other Outpatient Services (Network/Non-network combined) including but not limited to: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services 100 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% NCS 20%	50% NCS 20%
Accidental Dental Services $3,000 limit per occurrence (Network and Non-network combined)	20%	50%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 90 visits • Occupational therapy:90 visits • Manipulation therapy: 24 visits • Speech therapy: 40 visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 $50/$50 PCP/SCP 20%	 50% 50%
Behavioral Health Service Mental Illness and Substance Abuse[1]: • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional.	 20% 20% $50/$50 20%	 50% 50% 50% 50%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	NCS	50%

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Prescription Drugs: *Essential Formulary		
• Network Retail Pharmacies: (30-day supply)	Tier 1 - $20 Tier 2 - $50 Tier 3 - $80	50%(min $30)[2]
• Diabetic test strips	No cost share	Not covered
• Preventive Rx	$20	50%(min $30)[2]
• Home Delivery Service: (90-day supply)	Tier 1 - $40 Tier 2 - $100 Tier 3 - $160	Not covered
• Diabetic test strips	No cost share	Not covered
• Preventive Rx	$20	Not covered
Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service.	Separate Rx Out of Pocket: $4,350 Single $8,700 Family	Rx Out of Pocket: Unlimited
Medicare Rx - Wrap		
Lifetime Maximum	Unlimited	Unlimited
Surgical Treatment of Morbid Obesity	Unlimited	Unlimited

Notes:

- All medical deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Pharmacy has its own out of pocket maximum.
- Deductible(s) apply only 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 calendar year in 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.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections.
- 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.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = calendar year
- 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 covered.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.
- Live Health Online (LHO) is covered at the PCP costshare

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.
3 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

*The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.

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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 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.