

Your Summary of Benefits



**Crawford County Community Schools
Blue Access® (PPO) – Plan 2
Effective: January 1, 2015**

Covered Benefits	Network	Non-Network
Deductible (Single/Family)		\$1,000/\$2,000
Out-of-Pocket Limit (Single/Family)		\$5,000/\$10,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) allergy testing MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products 	20%/20% 20% 20% 20%	40% 40% 40% 40%
Preventive Care Services Services included but not limited to: <ul style="list-style-type: none"> 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	40%
Emergency and Urgent Care Emergency Room Services <ul style="list-style-type: none"> facility/other covered services (copayment waived if admitted) Urgent Care Center Services <ul style="list-style-type: none"> MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products Allergy injections Allergy testing 	20% 20% 20%	20% 40% 40%
Inpatient and Outpatient Professional Services Include, but are not limited to: <ul style="list-style-type: none"> 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 except for: <ul style="list-style-type: none"> Unlimited days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 90 days for skilled nursing facility 	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	20%	40%
Other Outpatient Services (including but not limited to): <ul style="list-style-type: none"> Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. Home Care Services (Network/Non-Network combined) 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%	40%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical therapy: 45 Visits Occupational therapy: 45 visits Manipulation therapy: 24 visits Speech therapy: 40 visits Cardiac Rehabilitation: Unlimited Pulmonary Rehabilitation: Unlimited 	20%/20% 20%	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 Abuse¹: <ul style="list-style-type: none"> ○ 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% 20%/20% 20%	40%
Human Organ and Tissue Transplants² <ul style="list-style-type: none"> ○ Acquisition and transplant procedures, harvest and storage 	NCS	50%
Prescription Drug Options: Network Tier structure equals 1/2/3 (and 4, if applicable) <ul style="list-style-type: none"> ○ Network Retail Pharmacies: (30-day supply) Includes diabetic test strip ○ Home Delivery Service: (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Medicare Rx - Wrap Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	\$20/\$40/\$60 \$40/\$80/\$120	50%, min \$60 ³ Not covered
Lifetime Maximum Medical Surgical Treatment of Morbid Obesity	Unlimited Not covered	Unlimited Not covered

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 only to covered medical services listed with a percentage (%) coinsurance.
- Dependent Age: to end of the month which the child attains age 26
- 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 – Unlimited.

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- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.

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.

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.