Your Summary of Benefits

IU GA PPO
Blue Access® (PPO)
Effective January 1, 2017

Covered Benefits	Network	Non-Network
Deductible (Single/Family) (combined)	$0/$0	$500/$1,000
Out-of-Pocket Limit (Single/Family)	$2,000/$4,000	$4,000/$8,000
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	$25/$35 $5 20% 20%	50% 50% 50% 50%
Preventive Care Services[1] Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[2], 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	50%
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	 $150 $50 20% $5 20%	 $150 50% 50% 50% 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%
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Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 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	$200	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	50%
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) 100 visits (excludes IV Therapy) • Durable Medical Equipment, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% 20% 20%	50% 20% 20%
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: 20 visits • Cardiac Rehabilitation: Unlimited • Pulmonary Rehabilitation: Unlimited	 $25/$35 20%	 50% 50%
Accidental Dental: $3,000 limit (Network and Non-network combined)	20%	50%
Behavioral Health Services Mental Illness and Substance Abuse[3]: • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 $200 $25/$25 20%	 50%
Human Organ and Tissue Transplants[4] • Acquisition and transplant procedures, harvest and storage	NCS	50%

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Covered Benefits	Network	Non-Network
Lifetime Maximum		
Medical	Unlimited	Unlimited
Surgical Treatment of Morbid Obesity	Not covered	Not covered

Notes:

- All medical 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, 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.
- Network and non-network deductibles, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- 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.
- 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.
- 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

1Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
2 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
3 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.
4 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 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.