Your Summary of Benefits

Wabash Valley / West Central Indiana School Trust
Blue Access® for Health Savings Accounts
Effective October 1, 2018

Covered Benefits	Network	Non-Network
Embedded Deductible The single deductible does apply to family coverage	Single: $6,000 Family: $12,000	Single: $12,000 Family: $24,000
Out-of-Pocket Limit	Single: $6,000 Family: $12,000	Single: $12,000 Family: $24,000
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services 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	No copayment/coinsurance	30%
Emergency and Urgent Care • Emergency Room Services (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services	 0% 0%	 0% 30%
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	0%	30%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • Unlimited days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • Unlimited days for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
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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 Unlimited (excluding Prosthetic Devices, Limbs and Medical Supplies) • Prosthetic Devices Unlimited • Prosthetic Limbs Unlimited • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%
Accidental Dental Services Unlimited	0%	30%
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: Unlimited • Occupational therapy: Unlimited • Manipulation therapy: 50 visits • Speech therapy: Unlimited • Cardiac Rehabilitation: Unlimited • Pulmonary Rehabilitation: Unlimited	 0% 0%	 30% 30%
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.	0%	30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%
Lifetime Maximum **(Combined Network and Non-network)**	Unlimited	Unlimited

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Notes:

- All medical 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%.
- 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 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.
- Ambulance Non-network non-emergency use limited to $50,000 per benefit period.
- 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 – Unlimited.

1 We encourage you to review the Schedule of Benefits for limitations.
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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.