Your Summary of Benefits

Gold Plan

Lutheran Senior Services
Blue Access/Blue Access Choice® PPO
Effective 01/01/2019

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$1,200/$2,400	$3,000/$6,000
Out-of-Pocket Limit (Single/Family)	$3,500/$7,000	$6,000/$12,000
Physician Home and Office Services (PCP/SCP)	$25/$45	40%
Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:		
• allergy injections (PCP and SCP)	$5	40%
• allergy testing	20%	40%
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	20%	40%
Preventive Care Services Services included but not limited to:		
• Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], 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 cost share	40%
• Immunizations through age 5	No cost share	No cost share
Emergency and Urgent Care		
Emergency Room Services	$300	$300
• **facility/other covered services** (copayment waived if admitted)		
Urgent Care Center Services	$50	40%
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	20%	40%
• Allergy injections	$5	40%
• **Allergy testing**	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to:	20%	40%
• Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams		
Blue 9.0		

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Inpatient Facility Services 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 Network/Non-Network combined for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
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 100 visits (excludes IV Therapy) (Network/Non-Network combined) • Durable Medical Equipment, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% See note below for cost share details No cost share 20%	40% See note below for cost share details No cost share 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/Manipulation therapy excluding Chiropractic Services: 20 visits • Occupational therapy: 20 visits • Chiropractic Services: 26 visits(Network Only) • Speech therapy: Unlimited visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	$25/$45 20% See note below for cost share details	40% 40% See note below for cost share details
Accidental Dental Services $3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	40%

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Behavioral Health Services[2]: **Mental Health and Substance Abuse** **(Network and Non-Network)** • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	Benefits provided in accordance with Federal Mental Health Parity	40%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No cost share	40%

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 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 a percentage (%) coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Network and Non-network deductibles, 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
- 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.
- No cost share (NCS) means no deductible/copayment/coinsurance up to the maximum allowable amount. 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.
- 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.
- Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the office visit setting.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Live Health Online (LHO) is covered at the PCP costshare.

- Certain diabetic and asthmatic supplies, except diabetic test strips, have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies.
- Benefit period = calendar year
- Elective abortions are not covered.
- 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.
- Chiropractic services at 50% Network coinsurance up to the maximum allowable amount and the Deductible applies when Office Visit is Deductible and Coinsurance. Non-network settings not covered.
- DME at 50% coinsurance for both network and non-network services, excludes Prosthetics, Wigs, Diabetic Supplies, Asthma Supplies and Hearing aids will apply the plan's cost shares (common deductible/coinsurance).
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime

1. These covered services for age 6 and above are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit
2. We encourage you to review the Schedule of Benefits for limitations. .
3. Kidney and cornea are treated the same as any other illness and subject to the medical benefits.
4. **If applicable, all prescription drug expenses except tier 1, (Network Retail/Mail-service combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment applies. Once the RX deductible is met, the appropriate copayment applies.**
5. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date