



**WASHBURN UNIVERSITY**  
**Comprehensive Major Medical<sup>SM</sup>**

**Effective January 01, 2020 - December 31, 2020**

Your financial responsibility is based on your provider's network: PPO (Blue Choice) or Traditional (CAP). Maximum benefits are available when services are received from Blue Choice providers. Non-Blue Choice & Non-CAP: The difference between the payment allowance and provider charge, additional 20% non-PPO network coinsurance amount\*, deductible, coinsurance or copay amount. CAP (Non-Blue Choice): Additional 20% non-PPO network coinsurance amount\*, deductible, coinsurance or copay amount. Blue Choice: Deductible, coinsurance or copay amount.

\*Non-PPO Coinsurance limited to a combined \$2,000 per person, \$4,000 two-or more persons each benefit period.

| <b>Member Pays</b>   |   |
|--|---|
| <b>Deductible</b><br>(Per group anniversary benefit period)                                    | Base: \$2,000/\$6,000 individual/two-or-more persons<br>BuyUp: \$1,500/\$4,500 individual/two-or-more persons   |
| <b>Coinsurance</b><br>(Member portion for most services)                                       | 20% of allowed amounts after deductible has been met.   |
| <b>Coinsurance Maximum</b>   | \$2,000/\$6,000 individual/two-or-more persons.   |
| <b>Maximum Out-of-Pocket</b><br>(includes copays, deductible and coinsurance where applicable) | \$6,350/\$12,700 individual/two-or-more persons.  |
| <b>Doctor's Office Visits</b>  |   |
| <b>Home and office visits</b><br><b>Specialist</b>   | \$35 copay per visit<br>\$45 copay per visit  |
| <b>Telemedicine Visits</b>   | \$35 copay per visit.   |
| <b>Preventive care as defined by the Affordable Care Act</b>                                   | Paid at 100% of the allowable charge. Some of the services include:<br>Routine screenings<br>Preventive immunizations<br>Well-women visits/screenings<br>Contraceptive methods  |
| <b>Drug Coverage</b>   |   |
| <b>Prescription Drugs &amp; Mail Order</b>   | BlueRx Card \$15/\$75/\$125/\$250; Mail order is 2x copay with Select formulary. The quantity per prescription shall be the greater of a 34-day supply or 100 unit dosage, if defined as a maintenance drug. Designated Specialty Pharmacy. |
| <b>Medical Services</b>  |   |
| <b>Emergency medical transportation</b>  | Subject to deductible/coinsurance.  |
| <b>Inpatient surgery physician/surgical</b>  | Subject to deductible/coinsurance.  |
| <b>Inpatient facility fee</b>  | Subject to deductible/coinsurance.  |
| <b>Outpatient surgery physician/surgical</b>   | Subject to deductible/coinsurance.  |
| <b>Outpatient lab and radiology (Includes Advanced Imaging)</b>                                | Pays at 100% to a combined maximum of \$300 for each covered person, each benefit period then subject to deductible/coinsurance.  |
| <b>Emergency room</b>  | \$250 copay then subject to deductible/coinsurance.   |

| <b>Medical Services</b>  |                                    |
|--|------------------------------------|
| <b>Accidental Injury Services</b>  | Subject to deductible/coinsurance. |
| <b>Recovery/Special Needs</b>  |                                    |
| <b>Outpatient rehabilitation</b>   | Subject to deductible/coinsurance. |
| <b>Hospice</b>   | Subject to deductible/coinsurance. |
| <b>Home Social Work Visits</b>   | Subject to deductible/coinsurance. |
| <b>Mental Health</b>   |                                    |
| <b>Mental Illness &amp; Substance Use Disorders</b><br><u>Inpatient Services</u><br>Requires pre-admission certification from New Directions Behavioral Health at 1-800-952-5906 | Subject to deductible/coinsurance. |
| <b>Mental Illness &amp; Substance Use Disorders</b><br><u>Outpatient Services</u>  | \$35 copay per visit.              |
| <b>Other</b>   |                                    |
| <b>Maximum Lifetime Benefit</b>  | Unlimited.                         |
| <b>Eligible Dependents</b>   | Covered to age 26.                 |

**Exclusions:** The following procedures and all related services and supplies are not covered under this program. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression; duplicate benefits provided under federal, state or local laws, regulations or programs, except Medicaid; cosmetic or reconstructive surgery (except as stated in the certificate); any keratotomy procedures; charges for personal items; convalescent or custodial/maintenance care or rest cures; blood or payments to donors of blood; any service or supply related to the medical management of obesity except for eligible preventive services; charges for services by immediate relatives or by members of your household; acupuncture and admissions for acupuncture; services related to temporomandibular joint dysfunction syndrome over the amount specified in the certificate; any medically-aided insemination procedure; services related to the reversal of sterilization procedures; mental illness or substance use disorder services provided by a non-eligible provider; hearing aids; eyeglasses or contact lenses (except after the removal of cataracts); unnecessary services and admissions; services or supplies which are experimental or investigative in nature; services not specifically listed as benefits in the certificate; services covered and payable by any medical expense payment provision of any automobile insurance policy.

This is a brief summary of the coverage available under this program. It is not a legal document.  
The exact provisions of the benefits and exclusions are contained in the certificate.