



Summary of Benefits – 69014 St. Louis University

This Summary of Benefits summarizes your obligation towards the cost of certain covered services. Refer to your Summary Plan Document (SPD) for a detailed description of covered services and limitations or exclusions.

To receive in-network benefits, all covered services, except for Emergency Health Services, must be performed by a participating GHP-ASO provider or authorized in advance by the Plan. You are not required to select a Primary Care Physician or obtain referrals to see a specialist. Open Access members may see a participating specialist at any time without a referral. Treatment from a chiropractor or physician specializing in pain management or infertility services does require prior authorization by the physician.

BENEFITS AND SERVICES		MEMBER RESPONSIBILITY	
1.	Annual Deductible Total amount a plan member is required to pay each benefit period before he or she is eligible for certain health services. The Annual Deductible need only be met once per plan member per calendar year.	Individual	\$0
		Family	\$0
2.	Annual Out-of-Pocket Maximum Copayments, annual deductible and coinsurance apply to the annual out-of-pocket maximum per benefit period. The annual out-of-pocket maximum need only be met once per plan member per calendar year.	Individual	\$0
		Family	\$0
3.	Maximum Lifetime Benefit Combined total of all benefits.		Unlimited
4.	PCP/Preventive Care Office Visits Services include routine health assessment, well-child care, child health supervision services, immunizations and injections, vision examination and refraction, hearing test, annual gynecological examination and pap smear and mammogram screening.		\$10 Copay per visit
5.	Specialist/Outpatient Office Visits Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, surgery, allergy tests and treatment.		\$20 Copay per visit
6.	Chiropractic Services Coverage is provided for chiropractic services up to 26 visits; treatment plan is required.		\$20 Copay per visit
7.	Emergency Room Services Coverage is provided for worldwide emergency health services as defined in the SPD.		\$50 Copay per visit (waived if the patient is admitted)
8.	Emergency Ambulance Services Coverage is provided for Emergencies as defined in the SPD.		0% Coinsurance
9.	Urgent Care Services Urgent care services at participating alternate facilities both in and out of the service area are covered when authorized in advance by the Plan.		\$50 Copay per visit
10.	Maternity Care, Office Visits Covered services include pre-natal and post-natal care, examinations, tests and educational services.		\$10 Copay first visit only

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY
11.	Maternity Care, Inpatient Hospital Covered services include all physician services for mother and newborn(s), delivery, newborn nursery services and semi-private room.	0% Coinsurance
12.	Outpatient Services and Diagnostic Procedures and Tests Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient Surgery section.	0% Coinsurance
13.	Outpatient Surgery Benefits are provided for covered services rendered at an outpatient hospital or free standing surgery center.	0% Coinsurance
14.	Inpatient Hospital Services Unlimited coverage is provided for medically necessary physician and surgeon services, semi-private rooms, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.	0% Coinsurance
15.	Skilled Nursing Facility Coverage is provided in lieu of an inpatient hospital admission when approved by the Plan. Coverage is provided for a semi-private room.	0% Coinsurance Limited to 45 days per benefit period
16.	Home Health Care and Hospice Coverage is provided when services are rendered by participating providers and authorized in advance by the Plan.	0% Coinsurance
17.	Durable Medical Equipment Coverage is provided when services are rendered by participating providers and authorized in advance by the Plan.	0% Coinsurance
19.	Physical, Occupational and Speech Therapy Coverage is provided for medically necessary inpatient or outpatient physical, occupational and speech therapy when authorized in advance by the Plan.	0% Coinsurance
20.	Mental Health/Substance Abuse, Inpatient All mental health services must be prior authorized in advance by calling the GHP behavior health line toll free at 877-227-3520.	0% Coinsurance
21.	Mental Health/Substance Abuse, Outpatient All mental health services must be prior authorized in advance by calling the GHP behavior health line toll free at 877-227-3520.	\$20 Copay per visit