INDIANA UNIVERSITY

IU High Deductible Health Plan (HDHP) PPO & Health Savings Account

Benefit Summary 2012

Health Savings Account - JP Morgan Chase

Annual IU Contribution to Health Savings Account	• $1,200 for employee-only coverage • $2,400 when one or more family members are covered (all other coverage levels)
Annual Employee Contribution to Health Savings Account	• $300 minimum/$1,900 maximum for employee-only coverage • $300 minimum/$3,850 maximum when one or more family members are covered • Employees age 55 or older are allowed "catch-up" contributions up to an additional $1,000 annually.
Health Savings Account Features	• Contributions, interest, and investment earnings can be used to pay for IRS-qualified medical expenses; account funds are not subject to federal, state, or FICA taxes. • Balances roll over year to year and stay with the employee even after leaving the university. • Balances of $1,000 or more may be placed in an array of investment options.

Medical Benefits - Anthem Blue Access PPO Network

Service	In-Network Provider – Member Pays	Out-of-Network Provider – Member Pays
Medical Annual Deductible Applies to all services except wellness/preventive.	$1,200 for employee-only coverage $2,400 when one or more family members are covered	$2,400 for employee-only coverage $4,800 when one or more family members are covered
Covered Charges	Up to the Maximum Allowable Amount that In-Network providers accept as payment in full. The member is responsible for amounts above Maximum Allowable Amounts when Out-of-Network providers are used.	
Medical Out-of-Pocket Maximum[1] (All copays and deductibles apply toward this maximum)	$2,500 for employee-only coverage $5,000 when one or more family members are covered	$5,000 employee-only coverage $10,000 when one or more family members are covered
Physician Office Services • Primary care (PCP) visits/consultations • Specialist visits/consultations • High cost diagnostics, pharmaceuticals, durable medical equipment/ prosthetics, allergy testing	20% after deductible	40% after deductible
Preventive Services • Office Services (e.g. routine exams, well child visits, immunizations, labs, hearing exams, routine eye exam, and diabetic eye exam) • Hospital/Alternative Facility[2] Surgical Procedure (e.g. screening colonoscopy) • Non-surgical Hospital/Alternative Facility[2] services (pap tests, mammograms, PSA, and other lab services)	No copay or deductible	40% after deductible
Hospital/Alternative Facility[2] Outpatient Surgical Procedure	20% after deductible	40% after deductible (Maximum of 60 Physical Medicine/Rehabilitation Days)
Hospital Inpatient Services	20% after deductible	40% after deductible
Professional Services Provided during a Hospital Inpatient Stay or during an Outpatient/Alternative Facility[2] Surgical Procedure	20% after deductible	40% after deductible
Maternity Services	Covered as any other illness; subject to same copays, deductibles, and maximums.	
Emergency Room for Emergency Care No coverage unless an emergency	20% after deductible (Copay waived if admitted)	
Urgent Care Facility • Facility Visit • High cost diagnostics, pharmaceuticals, durable medical equipment/ prosthetics, allergy testing	20% after deductible	40% after deductible
Other Outpatient Services • Non-surgical outpatient services (examples: MRIs, C-Scans, Chemo-therapy, Ultrasounds, X-Rays, and other diagnostics) • Durable Medical Equipment (DME) • Home Care (Out-of-Network limited to 30 visits) • Outpatient laboratory services	20% after deductible	40% after deductible (Certain supplies may only be covered In-Network)
Outpatient Laboratory Services	20% after deductible	40% after deductible

[1] In-Network and Out-of-Network copays, deductibles, and maximums are separate and do not accumulate toward each other.
[2] Alternative Facilities include facilities (free standing or attached to a hospital) that are designated primarily for outpatient services like surgery, diagnostic testing (e.g. MRIs), or therapy/rehabilitation.

Medical Benefits (continued)

Service	In-Network Provider – Member Pays	Out-of-Network Provider – Member Pays
Outpatient Therapy Services • Combined In- and Out-of-Network limits apply • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services at Hospital/Alternative Facility **Limits apply to:** • Physical therapy (limited to 60 visits) • Occupational therapy (limited to 60 visits) • Manipulation therapy (limited to 12 visits) • Speech therapy (limited to 20 visits)	20% after deductible	40% after deductible
Precertification Requirements	Network providers are required to precertify all inpatient stays (except deliveries) and certain outpatient services, for example, high-cost procedures such as brain/spine MRIs, PET scans, and sleep studies. Network providers are responsible for knowing which services to precertify and for costs resulting from failing to do so. When a member receives services out-of-network, the member is responsible for precertifying services and any additional costs incurred by failure to precertify.	

Mental Health & Substance Abuse

(All services, both In- and Out-of-Network, must be preauthorized by Anthem Behavioral Health.)

Service	In-Network Provider – Member Pays	Out-of-Network Provider – Member Pays
Mental Health & Substance Abuse	Covered as any other illness; subject to same copays, deductibles, and maximums.	

Organ & Tissue Transplants - Blue Quality Centers for Transplants

Service	In-Network Provider – Member Pays	Out-of-Network Provider – Member Pays
Transplants Except kidney and cornea - covered as medical benefit.	20% after deductible	50% after deductible (does not count towards out-of-pocket maximum)

Outpatient Prescription Drug - Medco Retail Network and Mail Order/Accredo Specialty

Benefits are subject to certain prior authorization and quantity limit guidelines.
Certain diabetic and asthmatic supplies are covered in full but coverage is limited to network pharmacies only.

Service	In-Network Provider – Member Pays	Out-of-Network Provider – Member Pays
Retail Prescriptions (Up to 30-day supply)	20% after deductible* Specialty Drugs** are not covered at Retail	40% after deductible
Mail Order Prescriptions (Up to 90-day supply) and Specialty Drugs**		Not covered

*No deductible on preventive prescriptions.

**Specialty Drugs: High cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through mail order.

Partial List of Exclusions (complete list in Plan Booklet)

- Any service not medically necessary as determined by the Plan Administrator.
- Custodial care, convalescent, or "long-term" nursing care.
- Cosmetic surgery, procedures, and drugs.
- Services, supplies, and drugs for obesity or weight control, except surgery for morbid obesity.
- Radial keratotomy or similar procedures.
- Eyeglasses or contact lenses, except in aphasic patients and soft lenses or sclera shells for use as corneal bandages.
- Supportive devices for the feet, and routine foot care.
- Immunizations and exams required for enrollment in an insurance program, as a condition of employment, for licensing, or for other purposes such as camps or travel.
- Experimental/Investigative services.
- Artificial insemination; fertilization (such as in-vitro, GIFT, ZIFT) or procedures and testing related to fertilization; reversal of sterilization; infertility drugs and related services following the diagnosis of infertility.
- Drugs, devices, or services related to sex transformation, male or female sexual or erectile dysfunction or inadequacy regardless of the cause.
- Over-the-counter drugs; drugs not FDA approved.
- Drugs in excess of limits established by the plan.
- Non-sedating (3rd generation) antihistamines, such as Zyrtec and Allegra.
- Services for which coverage is provided by or required by law by a public/governmental agency, facility, or program.
- Services and supplies used to treat conditions to the extent that, according to generally accepted Professional Standards, such conditions are not amenable to favorable modification through medical treatment.
- Sclerotherapy for the treatment of varicose veins of the lower extremities.

This is a plan summary. The entire provisions of benefits and exclusions are contained in the Plan Booklet which can be obtained at hr.iu.edu/benefits. A hard copy of this booklet can be obtained by contacting the UHRS Publications Coordinator at enews@indiana.edu. In the event of a conflict with this document, the terms of the Plan Booklet will prevail. For more information please visit: hr.iu.edu/benefits.