INDIANA UNIVERSITY

IU Health Quality Partners (IUHQP) Exclusive Provider Plan

Benefit Summary 2012

Medical Benefits - IU Health Quality Partners Network

Residency Requirement	Eligibility is limited to employees residing in these counties: Blackford, Boone, Brown, Carroll, Clinton, Delaware, Greene, Hamilton, Hancock, Hendricks, Henry, Howard, Johnson, Lawrence, Madison, Marion, Monroe, Morgan, Owen, Putnam, Shelby, Tipton, & Tippecanoe.
Primary Care Physician (PCP)[1] Designation	Members designate a primary care physician for routine care and coordination of overall care from the IUHQP network. Services are exclusively provided by IUHQP providers (except emergencies away from home).

Service	In-Network Provider – Member Pays	Out-of-Network Provider – Member Pays
Medical Annual Deductible	None	No coverage except emergency.
Covered Charges	Covered charges only at IUHQP providers.	
Medical Out-of-Pocket Maximum Prescription Drug deductibles/copays are excluded from the out-of-pocket limits.	$2,400 ($7,200 family)	
Physician Office Services • Primary care (PCP)[1] visits/consultations/therapy • Specialist visits/consultations/therapy • High cost diagnostics, pharmaceuticals, durable medical equipment/ prosthetics, allergy testing	$30 copay per Primary Care visit $40 copay per Specialist visit 15% copay	
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 Procedures (e.g. screening colonoscopy) • Non-surgical Hospital/Alternative Facility[2] services (pap tests, mammograms, PSA, and other lab services)	No copay	
Hospital/Alternative Facility[2] Outpatient Surgical Procedure	$200 per procedure	
Hospital Inpatient Services	$400 per admission	
Professional Services Provided during a Hospital Inpatient Stay or during an Outpatient/Alternative Facility[2] Surgical Procedure	No copay in addition to facility copay	
Maternity Services	Covered as any other illness; $400 copay for inpatient admission and no copay for office visits with OB delivering the newborn. 15% copay for services provided by other physicians.	
Emergency Room for Emergency Care No coverage unless an emergency.	$150 copay (Copay waived if admitted)	Paid as In-Network.
Urgent Care Facility • Facility Visit • High cost diagnostics, pharmaceuticals, durable medical equipment/ prosthetics, allergy testing	$75 copay 15% copay	Paid as In-Network when more than 50 miles from home.
Other Outpatient Services • Non-surgical outpatient services (examples: MRIs, C-Scans, Chemotherapy, Ultrasounds, X-Rays, and other diagnostics) • Durable Medical Equipment (DME) • Home Care (Out-of-Network limited to 30 visits) • Outpatient laboratory services	15% copay	No coverage except emergency.
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[2] **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)	$30/$40 copay per therapy visit 15% copay per therapy visit	

[1] Primary care is a practitioner specializing in family or general practice, internal medicine, or pediatricians that provide initial or basic care.
[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)

Precertification Requirements	Certain healthcare services and Prescription Drugs require pre-certification before receiving services. All inpatient stays (except deliveries) also required pre-certification. Network providers are responsible for knowing which services to precertify and for costs resulting from failing to do so. There is no coverage for out-of-network services.

Mental Health & Substance Abuse

(All services must be preauthorized by IU 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 copay and maximums.	No coverage except emergency.

Organ & Tissue Transplants

Service	In-Network Provider – Member Pays	Out-of-Network Provider – Member Pays
Transplants Except kidney and cornea - covered as medical benefit.	15% copay (see plan document for limits)	No coverage except emergency.

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

Benefits are subject to certain prior authorization and quantity limit guidelines. Benefits do not count toward the out-of-pocket maximum. 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)	• No deductible • Tier 1 - $8 (For brand with generic, member pays generic copay and cost difference between brand and generic.) • Tier 2 - $25 • Tier 3 - $45 • Specialty Drugs* are not covered at Retail	50% copay plus amounts above the network's discounted price
Mail Order Prescriptions (Up to 90-day supply) and Specialty Drugs*	• No deductible • Tier 1 - $20 (For brand with generic, member pays generic copay and cost difference between brand and generic.) • Tier 2 - $62 • Tier 3 - $112	Not Covered

Three-Tier Prescription Copays: Within the brand generic categories, drugs are assigned a copay "tier" based on cost and therapeutic value compared to other drugs. Tier 1 drugs are generics; Tier 2 drugs are preferred brands; Tier 3 drugs include non-preferred brand drugs.

*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.