

## IU PPO \$900 Deductible Healthcare Plan - Benefit Summary

This summary describes essential features of the benefit plan, and is not intended to be a full description of benefits. The complete plan is described in the PPO \$900 Plan booklet, which can be obtained at [www.indiana.edu/~uhrs/benefits](http://www.indiana.edu/~uhrs/benefits). If you would like a hard copy of this booklet mailed to you, please contact the UHRS Publications Coordinator at (812) 855-2985.

<b>Medical Benefits — In-Network Providers: Anthem Blue Access (Indiana) and BCBS PPO Networks (Outside Indiana)</b>		
Service	In-Network Member Pays	Out-of-Network Member Pays
<b>Medical Annual Deductible</b> Applies to all services except wellness, emergency, prescriptions, mental health, and transplant benefits.	\$900 individual/\$2,700 family	\$900 individual/\$2,700 family
<b>Covered Charges</b>	Up to Usual & Reasonable (U&R) for non-network providers; network providers accept network fee schedule as payment in full; member is responsible for non-network provider charges above U&R	
<b>Medical Copay</b>	10% after deductible.	30% after deductible.
<b>Medical Out-of-Pocket Maximum</b> (includes deductible and copays)	\$2,400 individual (\$6,700 family) then there is no Medical Copay. (Deductibles and copays apply to the maximum except Rx and Mental Health/Chemical Dependency)	
<b>Physician Office Services</b> <ul style="list-style-type: none"> <li>• Primary, specialist visits/consultations</li> <li>• Labs, x-rays, and diagnostic services</li> <li>• Allergy testing and serums</li> <li>• Surgery</li> </ul>	10% medical copay after deductible.	30% medical copay after deductible.
<b>Hospital/Facility Outpatient</b> <ul style="list-style-type: none"> <li>• Lab, x-rays, diagnostic, therapy</li> <li>• Surgery operating and recovery room</li> <li>• Anesthesia services</li> </ul>		
<b>Hospital Inpatient Services</b> Limits: 60 days inpatient physical medicine and rehab combined In- and Out-of-Network.		
<b>Wellness/Preventive Services</b> Limits: Exams or immunizations for insurance sports, camps, employment, licensing or travel are excluded.	10% medical copay. (Does not apply towards deductible)	30% medical copay. (Does not apply towards deductible.)
<b>Maternity Services</b>		
<b>Emergency Room for Emergency Care</b>	\$100 copay (Nonemergency services provided in the Emergency Room are not covered.)	
<b>Urgent Care Facility</b>	10% after deductible.	
<b>Durable Medical Equipment (DME), Medical Supplies and Appliances</b>		
<b>Therapy: Physical, Occupational, Speech</b> Maximum visits per benefit year: Physical/Occupational - 60 visits Speech - 20 visits Spinal Manipulations - 12 visits	10% copay after deductible.	30% copay after deductible.
<b>Home Health Care</b>	10% copay after deductible.	30% copay after deductible. (30-day maximum)
<b>Vision</b>	One routine eye exam, including refraction, subject to applicable in-network or out-of-network medical copay; no deductible. A routine eye exam is defined as an annual exam performed to detect undiagnosed eye health problems and to measure visual acuity (refraction). An annual eye exam for those with diabetes is covered as routine.	

**Medical Benefits (continued)**

**Precertification Requirements**

Network providers are required to precertify all inpatient stays (except deliveries) and certain outpatient services, for example:

- Hysterectomy
- Septoplasty/Rhinoplasty
- Pediatric therapies
- High-cost procedures, such as brain/spine MRIs, PET scans, sleep studies
- Mastectomy/Reconstructive surgery
- DME/Prosthetics
- Hospice and home health care

**Mental Health/Chemical Dependency: IU Psychiatric Management Provider Network**

All services, both In- and Out-of-Network, must be authorized by IUPM to be covered

Service	In-Network Member Pays	Out-of-Network Member Pays
<b>Inpatient</b>	<ul style="list-style-type: none"> <li>• \$250 deductible</li> <li>• 10% copay until copay equals \$500 per episode, then there is no copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$500 deductible per admission</li> <li>• 20% copay on the first \$2,500 of covered charges, then 40% of covered charges</li> <li>• No copay maximum</li> <li>• Enrollee is responsible for amounts above U&amp;R</li> </ul>
<b>Outpatient</b>	<ul style="list-style-type: none"> <li>• \$20 copay per visit</li> <li>• \$50 Emergency Room copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$30 per visit</li> <li>• \$50 maximum per covered visit</li> <li>• \$50 Emergency Room deductible</li> </ul>

**Organ and Tissue Transplants: Blue Quality Centers for Transplants**

Service	In-Network Member Pays	Out-of-Network Member Pays
<b>Transplants</b> (except kidney and cornea covered as medical benefit)	<ul style="list-style-type: none"> <li>• No deductible</li> <li>• No copay</li> </ul>	50% copay after deductible. (does not count towards out-of-pocket maximum)
<b>Lifetime Maximum</b>	\$2,000,000 per member.	

**Outpatient Prescription Drug - Anthem Prescription Retail Network/NextRx Mail Order**

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 Member Pays	Out-of-Network Member Pays
<b>Retail Prescriptions</b> (up to 30-day supply)	<ul style="list-style-type: none"> <li>• No deductible</li> <li>• \$8 generic and brands with generic*</li> <li>• \$20 low-cost brands (up to \$65)**</li> <li>• \$40 high-cost brands (\$65 or more)**</li> <li>• Noncovered w/network discount - 100%</li> </ul>	50% copay, plus amounts above the network's discounted price
<b>Mail Order Prescriptions</b> (up to 90-day supply)	<ul style="list-style-type: none"> <li>• No deductible</li> <li>• \$20 generic and brands with generic*</li> <li>• \$45 low-cost brands (up to \$65)**</li> <li>• \$90 high-cost brands (\$65 or more)**</li> <li>• Noncovered w/network discount - 100%</li> </ul> <p>* For brand with generic, member pays generic copay and cost difference between brand and generic **Brand costs are higher when generic is available.</p>	Not covered.

**Partial List of Exclusions (Complete list in Section F of the PPO \$900 Deductible Plan Booklet)**

<ul style="list-style-type: none"> <li>• Any service not medically necessary as determined by the Plan Administrator.</li> <li>• Custodial care, convalescent, or "long-term" nursing care.</li> <li>• Cosmetic surgery, procedures, and drugs.</li> <li>• Services, supplies, and drugs for obesity or weight control, except surgery for morbid obesity.</li> <li>• Radial keratotomy or similar procedures.</li> <li>• Eyeglasses or contact lenses, except in aphasic patients and soft lenses or sclera shells for use as corneal bandages.</li> <li>• Supportive devices for the feet, and routine foot care.</li> <li>• 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.</li> <li>• Experimental/Investigative services.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Drugs, devices, or services related to sex transformation, male or female sexual or erectile dysfunction or inadequacy regardless of the cause.</li> <li>• Over-the-counter drugs; drugs not FDA approved.</li> <li>• Drugs in excess of limits established by the plan.</li> <li>• Non-sedating (3rd generation) antihistamines, such as Zyrtec and Allegra.</li> <li>• Services for which coverage is provided by or required by law by a public/governmental agency, facility, or program.</li> <li>• 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.</li> </ul>
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