

IU PPO \$900 Deductible — Benefit Summary

This is a plan summary. The entire provisions of benefits and exclusions are contained in the Certificate and Schedule of Benefits which can be obtained at 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. In the event of a conflict with this document, the terms of the Schedule of Benefits will prevail.

Medical Benefits — Anthem Blue Access PPO Network		
Service	In-Network Provider - Member Pays	Out-of-Network Provider - Member Pays
Medical Annual Deductible	\$900 individual/\$2,700 family	\$900 individual/\$2,700 family
Covered Charges	Up to the Maximum Allowable Amount that In-Network providers accept as payment in full under their Anthem participation agreement. The member is responsible for amounts above Maximum Allowable Amounts when Out-of-Network providers are used.	
Medical Out-of-Pocket Maximum (All copays and deductibles, except prescription drug and human organ transplants, apply toward this maximum)	\$2,400 (\$7,200 family) ¹	\$2,400 (\$7,200 family) ¹
Physician Office Services <ul style="list-style-type: none"> • Primary care (PCP)² visits/consultations • Specialist visits/consultations (labs billed by a physician's office have no copay in addition to the office visit copay) • High cost diagnostics, pharmaceuticals, durable medical equipment/prosthetics, allergy testing 	10% after deductible	30% after deductible
Wellness/Preventive Services <ul style="list-style-type: none"> • Office services (e.g. routine exams, well child visits, immunizations, labs, routine and annual diabetic eye exams, hearing exams) • Hospital/Alternative Facility³ Surgical Procedure (e.g. screening colonoscopy) • Non-surgical Hospital/Alternative Facility services (pap tests, mammograms, PSA, and other lab services) 	10% copay (No deductible)	30% after deductible
Hospital/Alternative Facility³ Outpatient Surgical Procedure	10% after deductible	30% after deductible
Hospital Inpatient Services	10% after deductible	30% after deductible (Maximum of 60 Physical Medicine/Rehabilitation Days)
Professional Services Provided during a Hospital Inpatient Stay or during an Outpatient/Alternative Facility³ Surgical Procedure	10% after deductible	30% 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)	\$100 copay (Copay waived if admitted.)	
Urgent Care Facility <ul style="list-style-type: none"> • Facility Visit • High cost diagnostics, pharmaceuticals, durable medical equipment/prosthetics, allergy testing 	10% after deductible	30% after deductible
Other Outpatient Services <ul style="list-style-type: none"> • Non-surgical outpatient services (examples: MRIs, C-Scans, Chemotherapy, Ultrasounds, xrays, mammograms, stress tests and other diagnostics) • Home Care (out-of-network limited to 30 visits) • Durable Medical Equipment • Physical therapy (limited to 60 visits) • Occupational therapy (limited to 60 visits) • Manipulation therapy (limited to 12 visits) • Speech therapy (limited to 20 visits) 	10% after deductible	30% after deductible (Certain supplies may only be covered In-Network)
Outpatient Laboratory Services <ul style="list-style-type: none"> • Independent Laboratory Network • Other outpatient labs 	No copay 10% copay	30% after deductible

¹ In-Network and Out-of-Network copays, deductibles, and maximums are separate and do not accumulate toward each other.

² Primary care is a practitioner specializing in family or general practice, internal medicine, pediatrics, geriatrics, or obstetrics/gynecology that provides initial or basic care.

³ 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

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, 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 and Substance Abuse - Anthem Behavioral Health

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 and Substance Abuse	Covered as any other illness; subject to same copays, deductibles and maximums.	

Organ and 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)	No copay (see plan document for limits)	50% copay after deductible. (does not count towards out-of-pocket maximum)
Lifetime Maximum	\$2,000,000 Lifetime Maximum Benefit per member	

Outpatient Prescription Drug - Anthem Prescription Retail Network/Express Scripts 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 Provider - Member Pays	Out-of-Network Provider - Member Pays
Retail Prescriptions (up to 30-day supply)	<ul style="list-style-type: none"> 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 Noncovered w/network discount - 100% 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*	<ul style="list-style-type: none"> 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 Noncovered w/network discount - 100% 	Not covered.

Three-Tier Prescription Copays: Within the brand and generic categories, drugs are assigned a copay "tier" based on cost and therapeutic value compared to other drugs. Tier 1 drugs are mostly preferred generics and some lower cost brand drugs that have the greatest therapeutic value; Tier 2 drugs are preferred brands and some low-cost generic drugs; Tier 3 drugs include mostly brand drugs that cost more compared to lower tiered drugs, but may also include some high-cost generics.

***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)

<ul style="list-style-type: none"> 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. Non-sedating (3rd generation) antihistamines, such as Zyrtec and Allegra. 	<ul style="list-style-type: none"> 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. 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.
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