

Medical Benefits - Anthem Blue Access PPO Network

Service	In-Network Provider – Member Pays	Out-of-Network Provider – Member Pays
Medical Annual Deductible	\$900 (\$2,700 family)	\$900 (\$2,700 family)
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 Prescription Drug deductibles/copays and Non-network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits.	\$2,400 (\$7,200 family) ¹	\$3,000 (9,000 family) ¹
Physician Office Services <ul style="list-style-type: none"> Primary care (PCP) visits/consultations/therapy Specialist visits/consultations/therapy NOTE: labs billed by a physician's office (Physician or Specialist) have no copay in addition to the office visit copay <ul style="list-style-type: none"> High cost diagnostics, pharmaceuticals, durable medical equipment/prosthetics, allergy testing 	20% after deductible	30% after deductible
Preventive Services <ul style="list-style-type: none"> Office Services (e.g. routine exams, well child visits, immunizations, labs, hearing exams, routine eye exam, and diabetic eye exam) Hospital/Alternative Facility² Surgical Procedures (e.g. screening colonoscopy) Non-surgical Hospital/Alternative Facility² services (pap tests, mammograms, PSA, and other lab services) 	No copay or deductible	30% after deductible
Hospital/Alternative Facility² Outpatient Surgical Procedure	20% after deductible	30% after deductible
Hospital Inpatient Services	20% 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 Facility² Surgical Procedure	20% 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.	\$150 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 	\$75 copay 20% after deductible	30% after deductible
Other Outpatient Services <ul style="list-style-type: none"> 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) 	20% after deductible	30% after deductible (Certain supplies may only be covered In-Network)
Outpatient Therapy Services (Combined In- and Out-of-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services at Hospital/Alternative Facility² Limits apply to: <ul style="list-style-type: none"> 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	30% after deductible
Outpatient Laboratory Services <ul style="list-style-type: none"> Independent Laboratory Network Other outpatient labs 	No copay 20% after deductible	30% 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.	

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.

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.	No copay (see plan document for limits)	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. 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 • 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 	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)

- | | |
|---|---|
| <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. • Artificial insemination; fertilization (such as in-vitro, GIFT, ZIFT) or procedures and testing | <ul style="list-style-type: none"> 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.