## MEDICAL BENEFITS—ANTHEM BLUE ACCESS PPO NETWORK
Anthem National PPO (BlueCard PPO) network in other states, Anthem Blue Cross Blue Shield Global Core network overseas

### 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.

### 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. When a member receives services out-of-network, the member is responsible for precertifying services and any additional costs incurred by failure to precertify.

### Service | In-Network—Member Pays | Out-of-Network—Member Pays
---|---|---
**Annual Deductible**
Applies to all medical services except preventive | $500 individual | $900 individual |
| | $1,500 family | $2,700 family |

**Medical Out-of-Pocket Maximum (OOPM)**
All coinsurances and deductibles apply to OOPM | $2,400 individual | $6,850 individual |
| | $7,200 family | $13,700 family |

### Ambulance Services (when Medically Necessary)
20% after deductible
No coverage unless an emergency

### Emergency Room for Emergency Medical Condition
$150 copay
Copay waived if admitted

### Hearing Care
- Office visit–audiometric exam/hearing evaluation test
- Hearing Devices/Hearing Aids
  - Dependents under age 18 limit 1 per ear every 36 months
  - Adults age 18 & up max of $3,000 once every 5 years for one/both ears

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<th>20% after deductible</th>
<th>40% after deductible</th>
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### Home Health Care Services
- Maximum 30 Out-of-Network home health care visits
- Private Duty Nursing only covered in the home

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<th>20% after deductible</th>
<th>40% after deductible</th>
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### Hospice Care Services
No charge

### Hospital Inpatient Services (Precertification required)
- Room and board (semiprivate or ICU/CCU)
- Hospital services & supplies (x-ray, lab, anesthesia, surgery (precertification required), etc.)
- Physician services (surgeon, anesthesiologist, etc.)

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### Maternity Care
Covered as any other medical condition.
Subject to same deductibles, coinsurance, and maximums.

### Medical Supplies & Equipment
- Medical supplies
- Durable medical equipment (DME)
- Prosthetic appliances (external)

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### Outpatient Hospital/Facility Services
- Outpatient facility
- Lab and x-ray services
- Physician services (surgeon, anesthesiologist, etc.)

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### Physician Office Services
- Primary care (PCP) & Specialist visits/consultations
- Office surgery, telehealth, diagnostic services, allergy testing & treatment
- Prescription injectables/prescriptions dispensed in physician’s office

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### Preventive Services
- Office Services (e.g. routine exams, well child visits, immunizations, labs, routine vision and hearing exams, pelvic exams, STI screenings)
- Hospital/Facility Procedures (e.g. screening colonoscopy, pap tests, mammograms, PSA test)
- Women’s contraceptive services (e.g. IUDs, implanted and injectable hormones, and sterilization)

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<th>0</th>
<th>40% after deductible</th>
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### Therapy Services (Outpatient)
Combined in- and out-of-network limits apply to:
- Physical/Occupational/Speech Therapy: 140 visits combined
- Manipulation Therapy: 12 visits
- Cardiac Rehabilitation: Unlimited
- Pulmonary Rehabilitation: Unlimited

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### Urgent Care Clinic Visit
$75 copay

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1 In-Network and Out-of-Network deductibles, coinsurance, and maximums are separate and do not accumulate toward each other.
### Behavioral Health & Substance Use

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health &amp; Substance Use</td>
<td>Covered as any other medical condition. Subject to same deductibles, coinsurance, and maximums. Residential BH/SA covered as inpatient.</td>
<td></td>
</tr>
</tbody>
</table>

### Human Organ & Tissue Transplants—Blue Distinction Centers for Transplants

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
<td>Covered at 100% (see plan document for limits)</td>
<td>50% after deductible (does not count towards OOP max)</td>
</tr>
</tbody>
</table>

### Outpatient Prescription Drugs—CVS Caremark

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 in-network pharmacies only.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
<th>Limitations/Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Generic)</td>
<td>Retail (30-day supply): $8 Mail Order (90-day supply): $20</td>
<td>Out-of-Pocket limit for In-Network Prescriptions:</td>
<td></td>
</tr>
<tr>
<td>Tier 2 (Preferred Brand)</td>
<td>Retail (30-day supply): $25 Retail at CVS Pharmacies (90-day supply): $62 Mail Order (90-day supply): $62</td>
<td>50% coinsurance plus amounts above the network’s discounted price</td>
<td>$6,300 individual $10,200 family</td>
</tr>
<tr>
<td>Tier 3 (Non-Preferred Brand)</td>
<td>Retail (30-day supply): $45 Retail at CVS Pharmacies (90-day supply): $112 Mail Order (90-day supply): $112</td>
<td>Mail Order only covered In-Network. Copays do not apply toward deductible.</td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs (30-day supply)</td>
<td>Tier 1 (Generic): $20 Tier 2 (Preferred Brand): $62 Tier 3 (Non-Preferred Brand): $112</td>
<td>No Coverage</td>
<td>Coverage limited to In-Network Mail Order only.</td>
</tr>
</tbody>
</table>

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

2 For a brand drug with a generic version available, members must pay the generic copay plus the cost difference between the brand and generic.

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

4 Medical expenses do not count toward the prescription out-of-pocket limit.

### Vision and Eyewear—Blue View Vision

See separate summary for full benefit details.

<table>
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<tr>
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<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Eye Exam</td>
<td>$10 copay, no deductible</td>
<td>$42 allowance</td>
</tr>
<tr>
<td>Vision Wear</td>
<td>Specific allowances and discounts. Highest level of benefit in-network. Some enhancements are not covered out-of-network. See the separate summary for details.</td>
<td></td>
</tr>
</tbody>
</table>

### Partial List of Exclusions

See the plan booklet for a full list of exclusions.

- Acupuncture
- Cosmetic surgery, procedures, and drugs.
- Dental care (Adult)
- Infertility treatment
- Custodial care, convalescent, or “long-term” nursing care.
- Private duty nursing in a hospital or skilled nursing facility.
- Supportive devices for the feet, and routine foot care.
- Routine eye care except as covered in Vision Benefit.
- Any service not medically necessary as determined by the Plan Administrator.
- Services and supplies for obesity or weight control, except surgery for morbid obesity.

This is a plan summary. The entire provisions are contained in the Plan Booklet which can be obtained at hr.iu.edu/benefits.