Anthem PPO $500 Deductible Plan

BENEFIT SUMMARY 2020

Medical Benefits–Anthem Blue Access PPO Network

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 Provider – Member Pays[1]	Out-of-Network Provider – Member Pays[1]
Annual Deductible Applies to all medical services except preventive.	**$500** per member **$1,500** family maximum	**$900** per member **$2,700** family maximum
Medical Out-of-Pocket Maximum (OOP max) All coinsurances & deductibles for medical services apply to OOP max.	**$2,400** per member **$7,200** family maximum	**$6,850** per member **$13,700** family maximum
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 and older maximum of $3000 once every 5 years for one or both ears.	**20%** after deductible	**40%** after deductible
Home Health Care Services • Maximum 30 Out-of-Network home health care visits • Private Duty Nursing only covered in the home	**20%** after deductible	**40%** after deductible
Hospice Care Services	**20%** after deductible	
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.)	**20%** after deductible	**40%** after deductible (maximum 60 physical medicine/ rehabilitation days)
Maternity Care	**Covered as any other medical condition**. Subject to same deductibles, coinsurance, and maximums.	
Medical Supplies & Equipment • Medical supplies • Durable medical equipment (DME) • Orthotics (foot and shoe) • Prosthetic appliances (external)	**20%** after deductible	**40%** after deductible (certain supplies may only be covered In-Network)
Outpatient Hospital/Facility Services • Outpatient facility • Lab and x-ray services • Physician services (surgeon, anesthesiologist, etc.)	**20%** after deductible	**40%** after deductible
Physician Office Services • Primary care (PCP) & Specialist visits/consultations • Office surgery, online visits, diagnostic services, allergy testing & treatment • Prescription injectables/prescriptions dispensed in the physician's office	**20%** after deductible	**40%** after deductible
Preventive Services • Office Services (e.g. routine exams, well child visits, immunizations, labs, hearing screenings) • Hospital/Facility Procedures (e.g. screening colonoscopy, pap tests, mammograms, PSA) • Women's contraceptive services (e.g. IUDs, implanted and injectable hormones, and sterilization)	**Covered at 100%** not subject to deductible	**40%** after deductible
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	**20%** after deductible	**40%** after deductible
Urgent Care Clinic Visit	**$75** copay	**40%** after deductible

[1] In-Network and Out-of-Network deductible, coinsurance, and maximums are separate and do not accumulate toward each other.

Behavioral Health & Substance Abuse

All services, both In- and Out-of-Network, must be preauthorized by Anthem Behavioral Health.

Service	In-Network Provider – Member Pays[1]	Out-of-Network Provider – Member Pays[1]
Behavioral Health & Substance Abuse	**Covered as any other medical condition**. Subject to same deductibles, coinsurance, and maximums. Residential BH/SA covered as inpatient.	

Human Organ & Tissue Transplants–Blue Distinction Centers for Transplants

Service	In-Network Provider – Member Pays[1]	Out-of-Network Provider – Member Pays[1]
Transplants Except kidney and cornea (covered as medical benefit)	**20%** after deductible	**50%** after deductible (does not count towards OOP max)

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 network pharmacies only.

Service	In-Network Provider – Member Pays[1]	Out-of-Network Provider – Member Pays[1]	Limitations, Exceptions, & Other Important Information
Tier 1 (Generic[2])	Retail (30-day supply): **$8** Retail at CVS Pharmacies (90-day supply): **$20** Mail Order (90-day supply): **$20**	**50%** coinsurance plus amounts above the network's discounted price	Out-of-Pocket limit for In-Network Prescriptions[4]: • **$5,750** employee-only • **$9,100** all other coverage levels Mail Order only covered In-Network. Copays do not apply toward deductible.
Tier 2 (Preferred Brand)	Retail (30-day supply): **$25** Retail at CVS Pharmacies (90-day supply): **$62** Mail Order (90-day supply): **$62**		
Tier 3 (Non-Preferred Brand)	Retail (30-day supply): **$45** Retail at CVS Pharmacies (90-day supply): **$112** Mail Order (90-day supply): **$112**		
Specialty Drugs[3] (30-day supply)	Tier 1 (Generic[2]): **$20** Tier 2 (Preferred Brand): **$62** Tier 3 (Non-Preferred Brand): **$112**	No Coverage	Coverage limited to In-Network Mail Order only.

Three-Tier Prescription Copay: Within the brand and generic categories, drugs are assigend 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 brand with generic, members pay generic copayment 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.

Blue View Vision (See separate summary for benefit details)

Service	In-Network Provider – Member Pays[1]	Out-of-Network Provider – Member Pays[1]
Annual Eye Exam Annual comprehensive eye exam and refraction	**$10** copay, no deductible	**$42** allowance
Vision Wear Contacts, frames, and lenses	Specific allowances and discounts. Highest level of benefit in-network. Some enhancements are not covered out-of-network. See the separate summary for details.	

Partial List of Exclusions (Complete list in plan booklet)

- 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, supplies, and drugs for obesity or weight control, except surgery for morbid obesity.

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**.
In the event of a conflict with this document, the terms of the Plan Booklet will prevail.