

Your Summary of Benefits



IU GA PPO
 Blue Access® (PPO)
 Effective January 1, 2020

Covered Benefits	Network	Non-Network
Deductible (Single/Family) (combined)	\$0/\$0	\$500/\$1,000
Out-of-Pocket Limit (Single/Family)	\$2,000/\$4,000	\$4,000/\$8,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) allergy testing MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products 	\$25/\$35 \$5 20% 20%	50% 50% 50% 50%
Preventive Care Services¹ Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations ² , Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening	No copayment/coinsurance	50%
Emergency and Urgent Care Emergency Room Services <ul style="list-style-type: none"> facility/other covered services (copayment waived if admitted) Urgent Care Center Services <ul style="list-style-type: none"> MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products Allergy injections Allergy testing 	\$150 \$50 20% \$5 20%	\$150 50% 50% 50% 50%
Inpatient and Outpatient Professional Services Include, but are not limited to: <ul style="list-style-type: none"> Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 	20%	50%

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: <ul style="list-style-type: none"> 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 90 days for skilled nursing facility 	\$200	50%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	20%	50%
Other Outpatient Services (including but not limited to): <ul style="list-style-type: none"> Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. Home Care Services (Network/Non-Network combined) 100 visits (excludes IV Therapy) Durable Medical Equipment, Orthotics and Prosthetics Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	20% 20% 20%	50% 20% 20%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical / Occupational / Speech therapy: 140 combined visits Manipulation therapy: 12 visits Cardiac Rehabilitation: Unlimited Pulmonary Rehabilitation: Unlimited 	\$25/\$35 20%	50% 50%
Accidental Dental: \$3,000 limit (Network and Non-network combined)	20%	50%
Behavioral Health Services Mental Illness and Substance Abuse³: <ul style="list-style-type: none"> Inpatient Facility Services Physician Home and Office Visits (PCP/SCP) Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional 	\$200 \$25/\$25 20%	50%
Human Organ and Tissue Transplants⁴ <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage 	NCS	50%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Lifetime Maximum		
Medical	Unlimited	Unlimited
Surgical Treatment of Morbid Obesity	Not covered	Not covered

Notes:

- All medical deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Network and non-network deductibles, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections.
- NCS (No Cost Share) means no deductible/copayment/coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Benefit period = calendar year
- Mammograms (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Private Duty Nursing –Unlimited

1 Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

2 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

3 We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

4 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

Precertification:

Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: None

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.