INDIANA UNIVERSITY

2021
PLAN YEAR

MEDICAL PLAN SUMMARY

Anthem PPO $500

Anthem PPO $500 Deductible Health Plan

MEDICAL BENEFITS—ANTHEM BLUE ACCESS PPO NETWORK

Outside of the United States—BlueCross BlueShield Global Core 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—Member Pays[1]	Out-of-Network—Member Pays[1]
Annual Deductible Applies to all medical services except preventive	**$500** individual **$1,500** family	**$900** individual **$2,700** family
Medical Out-of-Pocket Maximum (OOPM) All coinsurances and deductibles apply to OOPM	**$2,400** individual **$7,200** family	**$6,850** individual **$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 and older maximum of $3,000 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	**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.)	**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) • 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 physician's office	**20%** after deductible	**40%** after deductible
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)	**$0** Covered at 100%—not subject to deductible	**40%** after deductible

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

Service	In-Network—Member Pays[1]	Out-of-Network—Member Pays[1]
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

BEHAVIORAL HEALTH & SUBSTANCE USE

All services (in- and out-of-network) must be preauthorized by Anthem Behavioral Health.

Service	In-Network—Member Pays[1]	Out-of-Network—Member Pays[1]
Behavioral Health & Substance Use	**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—Member Pays[1]	Out-of-Network—Member Pays[1]
Transplants Except kidney and cornea (covered as medical benefit)	**Covered at 100%** (see plan document for limits)	**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 in-network pharmacies only.

Service	In-Network—Member Pays[1]	Out-of-Network—Member Pays[1]	Limitations/Exceptions
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]: • **$6,150** individual • **$9,900** family 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 (30-day supply[3])	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.*

VISION AND EYEWEAR—BLUE VIEW VISION

See separate summary for full benefit details.

Service	In-Network—Member Pays[1]	Out-of-Network—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

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