INDIANA UNIVERSITY

# ANTHEM UNDER 65 PPO HDHP PLAN SUMMARY

## 2021 PLAN YEAR

HUMAN RESOURCES

| Anthem U65 PPO HDHP Monthly Premium Rate | | | |
|---|---|---|---|
| ***One participant*** | $393.70 | ***Participant and spouse*** | $1,048.58 |
| ***Participant and child(ren)*** | $753.25 | ***Participant and family*** | $1,187.30 |

## 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**<br>Applies to all medical/prescription services except preventive | **$1,700** employee-only coverage<br>**$3,400** all other coverage levels | **$3,400** employee-only coverage<br>**$6,800** all other coverage levels |
| **Medical Out-of-Pocket Maximum (OOP max)**<br>All coinsurances and deductibles apply to OOP max | **$3,400** employee-only coverage<br>**$6,800** all other coverage levels | **$6,800** employee-only coverage<br>**$13,600** all other coverage levels |
| **Emergency Room for Emergency Medical Condition and Ambulance Services (when Medically Necessary)** | **20%** after deductible<br>No coverage unless an emergency. | |
| **Hearing Care**<br>• Office visit–audiometric exam/hearing evaluation test<br>• Hearing Devices/Hearing Aids<br>– Dependents under age 18 limit 1 per ear every 36 months<br>– 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**<br>• Maximum 30 Out-of-Network home health care visits<br>• 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)**<br>• Room and board (semiprivate or ICU/CCU)<br>• Hospital services & supplies (x-ray, lab, anesthesia, surgery (precertification required), etc.)<br>• Physician services (surgeon, anesthesiologist, etc.) | **20%** after deductible | **40%** after deductible<br>(maximum 60 physical medicine/ rehabilitation days) |
| **Maternity Care** | **Covered as any other medical condition**.<br>Subject to same deductibles, coinsurance, and maximums. | |
| **Medical Supplies & Equipment**<br>• Medical supplies<br>• Durable medical equipment (DME)<br>• Orthotics (foot and shoe)<br>• Prosthetic appliances (external) | **20%** after deductible | **40%** after deductible<br>(certain supplies may only be covered In-Network) |
| **Outpatient Hospital/Facility Services**<br>• Outpatient facility<br>• Lab and x-ray services<br>• Physician services (surgeon, anesthesiologist, etc.) | **20%** after deductible | **40%** after deductible |
| **Physician Office Services**<br>• Primary care (PCP) & Specialist visits/consultations<br>• Office surgery, online visits, diagnostic services, allergy testing & treatment<br>• Prescription injectables/prescriptions dispensed in the physician's office | **20%** after deductible | **40%** after deductible |

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

## Medical Benefits *(continued)*

| Service | In-Network Provider – Member Pays[1] | Out-of-Network Provider – Member Pays[1] |
|---|---|---|
| **Preventive Services**<br>• Office Services (e.g. routine exams, well child visits, immunizations, labs, routine vision and hearing exams, pelvic exams, STI screenings)<br>• Hospital/Facility Procedures (e.g. screening colonoscopy, pap tests, mammograms, PSA test)<br>• Women's contraceptive services (e.g. IUDs, implanted and injectable hormones, and sterilization) | **Covered at 100%**<br>not subject to deductible | **40%** after deductible |
| **Therapy Services (Outpatient)**<br>Combined in- and out-of-network limits apply to:<br>• Physical/Occupational/Speech Therapy: 140 visits combined<br>• Manipulation Therapy: 12 visits<br>• Cardiac Rehabilitation: Unlimited<br>• Pulmonary Rehabilitation: Unlimited | **20%** after deductible | **40%** after deductible |
| **Urgent Care Clinic Visit** | **20%** after deductible | **40%** after deductible |

## 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**<br>Except kidney and cornea (covered as medical benefit) | **20%** after deductible | **50%** after deductible<br>(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] |
|---|---|---|
| **Retail Prescriptions**<br>(Up to 30-day supply or 90-day supply at CVS Pharmacies) | **20%** after deductible[2]<br>Specialty Drugs[3] are not covered at retail.<br>No coinsurance or deductible on most contraceptives. | **40%** after deductible |
| **Mail Order Prescriptions** (Up to 90-day supply)<br>**Specialty Drugs**[3] (Up to 30-day supply) | | **Not Covered** |

[2] No deductible on preventive prescriptions. For drug list, visit hr.iu.edu/benefits.
[3] Specialty Drugs: High cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through mail order.

## 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**<br>Annual comprehensive eye exam and refraction | **$10** copay, no deductible | **$42** allowance |
| **Vision Wear**<br>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.

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