INDIANA UNIVERSITY

Anthem PPO $500 Deductible Plan

2025 PLAN SUMMARY

Medical benefits—Anthem Blue Access PPO network in Indiana
Anthem BlueCard PPO network in other states, Anthem Blue Cross Blue Shield Global Core network overseas.

Covered charges: In-network providers agree to accept a set amount as full payment (the "maximum allowable amount"). If you go to an out-of-network provider, you may have to pay the difference between what they charge and the maximum allowable amount.

Pre-certification requirements: In-network providers must get approval in advance for hospital stays (except childbirth) and certain high-cost procedures, like brain/spine MRIs, PET scans, and sleep studies. If you go to an out-of-network provider, you are responsible for getting this approval and may have to pay extra if you don't.

Service	You pay in-network[1]	You pay out-of-network[1]
Annual deductible Applies to all medical services except preventive	**$500** individual **$1,500** family	**$900** individual **$2,700** family
Medical out-of-pocket (OOP) maximum All coinsurances and deductibles apply to OOP max	**$2,400** individual **$7,200** family	**$6,850** individual **$13,700** family
Ambulance services (when medically necessary)	**20%** after deductible (no coverage for non-emergencies treated in ER)	
Emergency room for emergency medical condition	**$150** 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	**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 (pre-certification required) • Room and board (semiprivate or ICU/CCU) • Hospital services & supplies (x-ray, lab, anesthesia, surgery (pre-certification required), etc.) • Physician services (surgeon, anesthesiologist, etc.)	**20%** after deductible	**40%** after deductible (maximum 60 physical medicine/rehabilitation days)
Marathon Health employee health center visits Claims apply towards your deductible and OOP maximum	**$0** for preventive care, labs **$35** for most other services	n/a
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, telehealth, 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
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

[1] *in-network and out-of-network deductible, coinsurance, and maximums are separate and do not accumulate toward each other.*

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Service	You pay in-network[1]	You pay out-of-network[1]
Travel benefit	Travel expense reimbursement up to **$2,000** for covered medical services that are no available within 100 miles of the member's home, subject to plan cost shares.	
Urgent care clinic visit	**$75** copay	**40%** after deductible

Behavioral health & substance use disorder

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

Service	You pay in-network[1]	You pay out-of-network[1]
Behavioral Health & Substance Use Disorder	**Covered as any other medical condition.** Subject to same deductibles, coinsurance, and maximums. Residential BH/SUD treatment covered as any other inpatient service.	

Human organ & tissue transplants—Blue Distinction Centers for Transplants

Service	You pay in-network[1]	You pay out-of-network[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. 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. Certain diabetic supplies are covered in full, but coverage is limited to in-network pharmacies only.

Service	You pay in-network[1]	You pay out-of-network[1]	Limitations/exceptions
Tier 1 (Generic[2])	Retail (30-day supply): **$8** Retail (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[3]: **$6,800** individual **$11,200** family Mail order only covered in-network. Copays do not apply toward deductible.
Tier 2 (Preferred Brand)	Retail (30-day supply): **$25** Retail (90-day supply): **$62** Mail Order (90-day supply): **$62**		
Tier 3 (Non-Preferred Brand)	Retail (30-day supply): **$45** Retail (90-day supply): **$112** Mail Order (90-day supply): **$112**		

Outpatient specialty drugs—Archimedes

Specialty drugs are high cost, scientifically engineered drugs that are usually injected or infused. Member services, prior authorizations, and claims processing for specialty medications are managed through Archimedes. Medication delivery is provided through AcariaHealth specialty pharmacy.

Service	You pay in-network[1]	You pay out-of-network[1]	Limitations/exceptions
Specialty Drugs (30-day supply)	Tier 1 (Generic[2]): **$20** Tier 2 (Preferred Brand): **$62** Tier 3 (Non-Preferred Brand): **$112**	No coverage	When using copay assistance, only the actual amount you pay counts towards your prescription out-of-pocket maximum.

Vision and eyewear—Anthem Blue View Vision

See separate summary for full benefit details.

Service	You pay in-network[1]	You pay out-of-network[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 and supplies for obesity or weight control, except surgery for morbid obesity.

[1] In-network and out-of-network deductible, coinsurance, and maximums are separate and do not accumulate toward each other.
[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] Medical expenses do not count toward the prescription out-of-pocket limit.