INDIANA UNIVERSITY

Anthem U65 PPO High Deductible Health Plan

2025 PLAN SUMMARY

Monthly Premiums			
One participant	$493.36	**Retiree and spouse**	$1,313.97
Participant and child(ren)	$943.88	**Family**	$1,487.80

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/prescription services except preventive	**$2,000** employee-only coverage **$4,000** all other coverage levels	**$4,000** employee-only coverage **$8,000** all other coverage levels
Medical out-of-pocket maximum All coinsurances and deductibles apply to OOP max	**$4,000** employee-only coverage **$8,000** all other coverage levels	**$8,000** employee-only coverage **$16,000** all other coverage levels
Emergency room for emergency medical condition and ambulance services (when medically necessary)	**20%** after deductible No coverage unless an emergency.	
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	**20%** after deductible	
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)
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) • Contraceptive services (e.g. IUDs, implanted/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	You pay in-network[1]	You pay out-of-network[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
Travel benefit	Travel expense reimbursement up to **$2,000** for covered medical services that are not available within 100 miles of the member's home, subject to plan cost shares.	
Urgent care clinic visit	**20%** after deductible	**40%** after deductible

Mental/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]
Mental/behavioral health & substance use disorder services	**Covered as any other medical condition.** Subject to same deductibles, coinsurance, and maximums. Residential treatment is 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)	**20%** after deductible	**50%** after deductible (does not count towards OOP max)

Outpatient prescription drugs—CVS Caremark

Benefits subject to prior authorization and quantity limit guidelines. Certain diabetic and asthmatic supplies are covered in full, but limited to in-network pharmacies only.

Service	You pay in-network[1]	You pay out-of-network[1]
Retail prescriptions (up to 90-day supply) **Mail order prescriptions** (up to 90-day supply)	**20%** after deductible[2] No coinsurance or deductible on most contraceptives.	Not covered

Specialty prescription 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 (up to 30-day supply)	**20%** after deductible	Not covered	When using copay assistance, only the actual amount you pay counts towards your plan deductibles/out-of-pocket maximums.

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] *No deductible on preventive prescriptions. For drug list, visit* ***hr.iu.edu/benefits****.*

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.