

ANTHEM UNDER 65 (U65) PPO HDHP SUMMARY**2022 PLAN YEAR**

Anthem U65 PPO HDHP Monthly Premium Rate			
One participant	\$ 407.37	Participant and spouse	\$ 1,084.99
One participant and child(ren)	\$ 779.40	Participant and family	\$ 1,228.53

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 Applies to all medical/prescription services except preventive	\$1,700 employee-only coverage \$3,400 all other coverage levels	\$3,400 employee-only coverage \$6,800 all other coverage levels
Medical Out-of-Pocket Maximum (OOP max) All coinsurances and deductibles apply to OOP max	\$3,400 employee-only coverage \$6,800 all other coverage levels	\$6,800 employee-only coverage \$13,600 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 <ul style="list-style-type: none"> • Office visit—audiometric exam/hearing evaluation test • Hearing Devices/Hearing Aids <ul style="list-style-type: none"> – 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 <ul style="list-style-type: none"> • 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 (Precertification required) <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Medical supplies • Durable medical equipment (DME) • Orthotics (foot and shoe) • Prosthetic appliances (external) 	20% after deductible	40% after deductible (certain supplies may only be covered In-Network)
Outpatient Hospital/Facility Services <ul style="list-style-type: none"> • Outpatient facility • Lab and x-ray services • Physician services (surgeon, anesthesiologist, etc.) 	20% after deductible	40% after deductible
Physician Office Services <ul style="list-style-type: none"> • Primary care (PCP) & Specialist visits/consultations • Office surgery, online visits, diagnostic services, allergy testing & treatment • 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 <ul style="list-style-type: none"> 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) 	Covered at 100% not subject to deductible	40% after deductible
Therapy Services (Outpatient) Combined in- and out-of-network limits apply to: <ul style="list-style-type: none"> 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	20% after deductible	40% after deductible

Behavioral Health & Substance Abuse

Many 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 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 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 (Up to 30-day supply or 90-day supply at CVS Pharmacies)	20% after deductible ² Specialty Drugs ³ are not covered at retail.	Not Covered
Mail Order Prescriptions (Up to 90-day supply) Specialty Drugs³ (Up to 30-day supply)		

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 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 (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 and supplies 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.