

## Blue Preferred Primary POS — Benefit Summary

This is a plan summary. The entire provisions of benefits and exclusions are contained in the Certificate and Schedule of Benefits which can be obtained at [www.indiana.edu/~uhhs/benefits](http://www.indiana.edu/~uhhs/benefits). If you would like a hard copy of this booklet mailed to you, please contact the UHRS Publications Coordinator at (812) 855-2985. In the event of a conflict with this document, the terms of the Certificate and Schedule of Benefits will prevail.

<b>Medical Benefits — Anthem Blue Preferred Primary Network</b>		
<b>Service</b>	<b>In-Network Provider - Member Pays</b>	<b>Out-of-Network Provider - Member Pays*</b>
<b>Medical Plan Annual Deductible</b>	None	\$500 per person/\$1,000 per family
<b>Medical Out-of-Pocket Maximum</b> (All copays and deductibles, except prescription drug and human organ transplants, apply toward this maximum)	\$2,000 (\$4,000 family)**	\$4,000 (\$8,000 family)**
<b>Maximum Allowable Charges</b>	Up to the Usual & Reasonable (U&R) amount that In-Network providers accept as payment in full under their Anthem participation agreement. The member is responsible for amounts above U&R reimbursements when Out-of-Network providers are used.	
<b>Lifetime Maximum</b>	\$5,000,000	
<b>Physician Office Services</b> • Primary, specialist visits/consultations • Labs, x-ray, and allergy services billed by the physicians office.	\$20 copay per visit	30%
<b>Preventive Services</b> • Routine exams, pap tests, well child visits, immunizations, mammograms, routine and annual diabetic eye exams, hearing exams, and other screenings.	\$20 copay per office visit (Immunizations and mammograms have no copay when rendered without an office visit)	30%
<b>Hospital Inpatient Services</b> • Physician and Ancillary Services • Facility Services	• No copay • \$250 per visit	30% (Maximum of 60 Physical Medicine/ Rehabilitation Days)
<b>Hospital Outpatient Services</b> • Physician Services • Facility Services	• No copay • \$75 per visit	30%
<b>Maternity</b>	Covered as any other medical service	
<b>Emergency Room for Emergency Care</b>	\$100 copay (no coverage unless an emergency)	
<b>Urgent Care Facility</b>	\$40 copay	
<b>Outpatient Therapy</b> Maximum visits per benefit year (combined In- and Out-of-Network) Physical/Occupational - 30 visits Speech - 20 visits Spinal Manipulations - 12 visits	\$20 copay per visit	30%
<b>Home Care</b>	No copay	30% (30-day maximum)
<b>Durable Medical Equipment (DME), Medical Supplies and Appliances</b>	20% copay	40% copay on DME (Certain supplies may only be covered In-Network)
<b>Vision / Hearing Exams</b>	\$20 copay	No benefit

\* It is important to note that the medical plan does NOT guarantee that all covered services will be available through In-Network providers. If an In-Network provider is not available, the service will be processed as an Out-of-Network expense, except in an emergency or when an Out-of-Network provider renders service while the member is an inpatient or outpatient in an In-Network facility. However, in any case, the member is responsible for amounts above maximum allowable charges.

\*\* In-Network and Out-of-Network copays, deductibles, and maximums are separate and do not accumulate toward each other.

<b>Mental Health and Substance Abuse - Anthem Behavioral Health</b>		
All services must be precertified in order to receive In-Network benefits.		
<b>Service</b>	<b>In-Network Provider - Member Pays</b> <small>(Services pre-authorized by Anthem Behavioral Health)</small>	<b>Out-of-Network Provider - Member Pays</b> <small>(Not pre-authorized by Anthem Behavioral Health)</small>
<b>Mental Health and Substance Abuse</b>	Covered as any other illness; subject to same copays, deductibles and maximums	
<b>Organ and Tissue Transplants - Blue Quality Centers for Transplants</b> <small>(Does not count toward out-of-pocket maximum)</small>		
<b>Service</b>	<b>In-Network Provider - Member Pays</b> <small>(Must have pre-authorization)</small>	<b>Out-of-Network Provider - Member Pays</b>
<b>Transplants</b> <small>(except kidney and cornea covered as medical benefit)</small>	No copay <small>(see plan document for limits)</small>	50%
<b>Lifetime Maximum</b>	\$1,000,000 Lifetime Maximum Benefit per member	
<b>Outpatient Prescription Drug - Anthem Prescription Management Network</b> <small>Benefits are subject to certain prior authorization and quantity limit guidelines. Benefits do not count toward the out-of-pocket maximum. Certain diabetic and asthmatic supplies are covered in full but coverage is limited to network pharmacies only.</small>		
<b>Service</b>	<b>In-Network Provider - Member Pays</b>	<b>Out-of-Network Provider - Member Pays</b>
<b>Retail Prescriptions</b> (up to a 30-day supply) • Generic • Brand formulary • Non-formulary	\$8 \$20 \$40	50%
<b>Mail Order</b> (up to a 90-day supply) • Generic • Brand formulary • Non-formulary	\$16 \$40 \$80	Not available
<b>Partial List of Exclusions</b> (Complete list in Plan Booklet)		
<ul style="list-style-type: none"> <li>• Any service not medically necessary as determined by the Plan Administrator.</li> <li>• Custodial care, convalescent, or “long-term” nursing care.</li> <li>• Cosmetic surgery, procedures, and drugs.</li> <li>• Services, supplies, and drugs for obesity or weight control, except surgery for morbid obesity.</li> <li>• Radial keratotomy or similar procedures.</li> <li>• Eyeglasses or contact lenses, except in aphasic patients and soft lenses or sclera shells for use as corneal bandages.</li> <li>• Supportive devices for the feet, and routine foot care.</li> <li>• Immunizations and exams required for enrollment in an insurance program, as a condition of employment, for licensing, or for other purposes such as camps or travel.</li> <li>• Experimental/Investigative services.</li> <li>• Artificial insemination; fertilization (such as in-vitro, GIFT, ZIFT) or procedures and testing related to fertilization; reversal of sterilization; infertility drugs and related services following the diagnosis of infertility.</li> <li>• Drugs, devices, or services related to sex transformation, male or female sexual or erectile dysfunction or inadequacy regardless of the cause.</li> <li>• Over-the-counter drugs; drugs not FDA approved.</li> <li>• Drugs in excess of limits established by the plan.</li> <li>• Non-sedating (3rd generation) antihistamines, such as Zyrtec and Allegra.</li> <li>• Services for which coverage is provided by or required by law by a public/governmental agency, facility, or program.</li> <li>• Services and supplies used to treat conditions to the extent that, according to generally accepted Professional Standards, such conditions are not amenable to favorable modification through medical treatment.</li> </ul>		