

## IU PPO-Plus Health Care Plan — Benefit Summary

This summary describes essential features of the benefit plan, and is not intended to be a full description of benefits. The complete plan is described in the PPO Plus Plan booklet, which can be obtained at [www.indiana.edu/~uhrs/benefits](http://www.indiana.edu/~uhrs/benefits). If you would like a hard copy of this booklet mailed to you, please contact the UHRS Publications Coordinator at (812) 855-2985.

<b>Medical Benefits — In-Network Providers: Anthem Blue Access (Indiana) and BCBS PPO Networks (Outside Indiana)</b>		
<b>Service/Provisions</b>	<b>In-Network Member Pays</b>	<b>Out-of-Network Member Pays</b>
<b>Plan Deductible</b>	None	\$300 per member
<b>Covered Charges</b>	Up to the network fee schedule, or Usual & Reasonable (U&R) for non-network providers; network providers accept network fee schedule as payment in full; member is responsible for non-network provider charges above U&R	
<b>Medical Copay</b>	10%	30%
<b>Medical Copay Maximum</b> (All copays and deductibles, except prescription drug, human organ transplants, and mental health apply toward this maximum)	\$1,000 (\$2,000 family) copay maximum, then there is no Medical Copay	\$3,000 (\$6,000 family) copay maximum, then there is no Medical Copay
<b>Office Visit Copay</b>	\$20 per visit	Medical Copay
<b>Hospital Inpatient Services</b> • Semiprivate room and board • Operating room, recovery, ancillary services (e.g., labs, x-rays, drugs)	Maximum of 60 inpatient physical medicine/rehabilitation days	
<b>Outpatient Facility</b> Operating room, recovery, ancillary services	10% Medical Copay	30% Medical Copay
<b>Professional Services (e.g., surgery fees)</b>		
<b>Durable Medical Equipment (DME), Medical Supplies and Appliances</b>		
<b>Home Health Care</b> (Out-of-Network: 30-day maximum)		
<b>Therapy: Physical, Occupational, Speech</b> Combined PT/OT limit per member, per Plan Year: 60 visits. ST limit per member, per Plan Year: 20 visits.	Office Visit Copay	
<b>Chiropractic Services / Osteopathic Manipulations</b> Limit per member, per Plan Year: 12 visits		
<b>Maternity Care and Delivery Services</b>	Paid the same as any other medical services	
<b>Wellness Services</b> Services for insurance, sports, employment, licensing, or travel are excluded	Office Visit Copay	30% Medical Copay
<b>Emergency Room for Emergency Care</b> Non-emergency services provided in Emergency Room are not covered	\$100 copay	
<b>Urgent Care Facility Copay</b>	\$40 copay	
<b>Ambulance for Emergency Transport</b>	No copay	
<b>Vision</b>	One routine eye exam, including refraction, subject to applicable in-network or out-of-network medical copay. A routine eye exam is defined as an annual exam performed to detect undiagnosed eye health problems and to measure visual acuity (refraction). An annual eye exam for those with diabetes is covered as routine.	

**Medical Benefits (continued)**

<b>Precertification Requirements</b>	<p>Network providers are required to precertify all inpatient stays (except deliveries) and certain outpatient services, for example:</p> <ul style="list-style-type: none"> <li>• Hysterectomy</li> <li>• Septoplasty/Rhinoplasty</li> <li>• Pediatric therapies</li> <li>• High-cost procedures, such as brain/spine MRIs, PET scans, sleep studies</li> <li>• Mastectomy/Reconstructive surgery</li> <li>• DME/Prosthetics</li> <li>• Hospice and home health care</li> </ul>
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**Mental Health/Chemical Dependency: IU Psychiatric Management Provider Network**

All services, both In- and Out-of-Network must be authorized by IUPM to be covered

Service	In-Network Member Pays	Out-of-Network Member Pays
<b>Inpatient</b>	<ul style="list-style-type: none"> <li>• \$250 deductible</li> <li>• 10% copay until copay equals \$500 per episode, then there is no copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$500 deductible per admission</li> <li>• 20% copay on the first \$2,500 of covered charges, then 40% of covered charges</li> <li>• No copay maximum</li> </ul>
<b>Outpatient</b>	<ul style="list-style-type: none"> <li>• \$20 copay per visit</li> <li>• \$50 Emergency Room copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$30 per visit</li> <li>• \$50 maximum per covered visit</li> <li>• \$50 Emergency Room deductible</li> </ul>

**Organ and Tissue Transplants: Blue Quality Centers for Transplants**

Service	In-Network Member Pays	Out-of-Network Member Pays
<b>Transplants:</b> Bone marrow, heart, lung, liver, pancreas, kidney/pancreas	<ul style="list-style-type: none"> <li>• No deductible</li> <li>• No copay</li> </ul>	50% up to a maximum benefit
<b>Lifetime Maximum</b>	\$1,000,000 per member.	

**Prescription Drugs**

Service	In-Network Member Pays	Out-of-Network Member Pays
<b>Prescriptions</b>	<p><b>Retail</b> (up to a 30-day supply):</p> <ul style="list-style-type: none"> <li>• No deductible</li> <li>• \$ 6 generic and brands with generic*</li> <li>• \$17 low-cost brands (up to \$65)</li> <li>• \$35 high-cost brands (\$65 or more)</li> <li>• Noncovered w/network discount - 100%</li> </ul> <p><b>Mail Order</b> (up to a 90-day supply) :</p> <ul style="list-style-type: none"> <li>• \$12 generic R<sub>x</sub></li> <li>• \$36 brand**, low cost R<sub>x</sub></li> <li>• \$75 brand**, high cost R<sub>x</sub></li> <li>• Noncovered w/network discount - 100%</li> </ul> <p>* For brand with generic, member pays generic copay and cost difference between brand and generic                      **Brand costs are higher when generic is available.</p>	50% copay, plus amounts above the network's discounted price

**Partial List of Exclusions (Complete list in Section F of the PPO-Plus Plan Booklet)**

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| <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> </ul> | <ul style="list-style-type: none"> <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> |
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