

IU PPO \$900 Deductible Healthcare 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 \$900 Plan booklet, which can be obtained at 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.

Medical Benefits — In-Network Providers: Anthem Blue Access (Indiana) and BCBS PPO Networks (Outside Indiana)		
Service/Provisions	In-Network Member Pays	Out-of-Network Member Pays
Plan Deductible The medical deductible applies to all services except wellness, emergency, prescriptions, mental health, and transplant benefits.	\$900 individual/\$2,700 family maximum.	\$900 individual/\$2,700 family maximum.
Covered Charges	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	
Medical Copay	10%	30%
Medical Copay Maximum	\$1,000 (\$3,000 family) copay maximum, then there is no Medical Copay.	\$1,000 (\$3,000 family) copay maximum, then there is no Medical Copay.
Physician Office and Hospital Services <ul style="list-style-type: none"> • Primary, specialist visits/consultations • Labs, x-rays, and diagnostic services • Allergy testing and serums • Surgery 	10% Medical Copay	30% Medical Copay
Hospital Inpatient Services Limits: 60 days inpatient physical medicine and rehab combined In- and Out-of-Network.		
Hospital/Facility Outpatient <ul style="list-style-type: none"> • Lab, x-rays, diagnostic, therapy • Surgery operating and recovery room • Anesthesia services 		
Therapy: Physical, Occupational, Speech Combined PT/OT limit per member, per Plan Year: 60 visits; ST limit per member, per Plan Year: 20 visits		
Maternity Care and Delivery Services		
Chiropractic Services/Osteopathic Manipulations Limit: 12 visits per Plan Year, per member		
Home Health Care (Out-of-Network: 30-day maximum)		
Durable Medical Equipment (DME), Medical Supplies and Appliances		
Wellness/Preventive Services Limits: Exams or immunizations for insurance sports, camps, employment, licensing or travel are excluded	10% Medical Copay	30% Medical Copay
Emergency Room for Emergency Care Nonemergency services provided in the Emergency Room are not covered.	\$100 copay	
Urgent Care Facility	10% Medical copay	
Ambulance for Emergency Transport	No copay	
Vision	One routine eye exam, including refraction, subject to applicable in-network or out-of-network medical copay; not subject to deductible. 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)

Precertification Requirements	<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"> • Hysterectomy • Septoplasty/Rhinoplasty • Pediatric therapies • High-cost procedures, such as brain/spine MRIs, PET scans, sleep studies • Mastectomy/Reconstructive surgery • DME/Prosthetics • Hospice and home health care
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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
Inpatient	<ul style="list-style-type: none"> • \$250 deductible • 10% copay until copay equals \$500 per episode, then there is no copay 	<ul style="list-style-type: none"> • \$500 deductible per admission • 20% copay on the first \$2,500 of covered charges, then 40% of covered charges • No copay maximum • Enrollee is responsible for amounts above U&R
Outpatient	<ul style="list-style-type: none"> • \$20 copay per visit • \$50 Emergency Room copay 	<ul style="list-style-type: none"> • \$30 per visit • \$50 maximum per covered visit • \$50 Emergency Room deductible

Organ and Tissue Transplants: Blue Quality Centers for Transplants

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

Prescription Drugs

Service	In-Network Member Pays	Out-of-Network Member Pays
Prescriptions	<p>Retail (up to a 30-day supply):</p> <ul style="list-style-type: none"> • No deductible • \$ 6 generic and brands with generic* • \$17 low-cost brands (up to \$65) • \$35 high-cost brands (\$65 or more) • Noncovered w/network discount - 100% <p>Mail Order (up to a 90-day supply) :</p> <ul style="list-style-type: none"> • \$12 generic R_x • \$36 brand**, low cost R_x • \$75 brand**, high cost R_x • Noncovered w/network discount - 100% <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 \$900 Deductible Plan Booklet)

<ul style="list-style-type: none"> • Any service not medically necessary as determined by the Plan Administrator. • Custodial care, convalescent, or “long-term” nursing care. • Cosmetic surgery, procedures, and drugs. • Services, supplies, and drugs for obesity or weight control, except surgery for morbid obesity. • Radial keratotomy or similar procedures. • Eyeglasses or contact lenses, except in aphasic patients and soft lenses or sclera shells for use as corneal bandages. • Supportive devices for the feet, and routine foot care. • 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. 	<ul style="list-style-type: none"> • 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. • Drugs, devices, or services related to sex transformation, male or female sexual or erectile dysfunction or inadequacy regardless of the cause. • Over-the-counter drugs; drugs not FDA approved. • Drugs in excess of limits established by the plan. • Non-sedating (3rd generation) antihistamines, such as Zyrtec and Allegra. • Services for which coverage is provided by or required by law by a public/ governmental agency, facility, or program. • 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. • Experimental/Investigative services.
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