Your Summary of Benefits

Anthem BlueCross BlueShield

Indiana University International Students/Scholars
Blue Access® (PPO)
Effective: August 1, 2020

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	Single / Family: $500 per person deductible	Single / Family: $750 per person deductible
Out-of-Pocket Limit (Single/Family)	Single: $2,000 Family: $4,000	
Physician Home and Office Services (PCP/SCP)* Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Indiana University Health Center Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	$25 copay after deductible $15 copay $25 copay after deductible $25 copay after deductible $20 copay after deductible	50% 50% 50% 50%
Preventive Care Services Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening	No copayment/coinsurance	50%
Emergency and Urgent Care **Emergency Room Services** • **facility/other covered services** (copayment waived if admitted) **Urgent Care Center Services** • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products • Allergy injections • Allergy testing	 $100 copay after deductible $50 copay after deductible $20 copay after deductible $25 copay after deductible $20 copay after deductible	 $100 copay after deductible 50% 50% 50%
Inpatient and Outpatient Professional Services Include, but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	**Inpatient:** $25 copay after deductible **Outpatient:** $50 copay after deductible	50%
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Inpatient Facility Services (Network/Non-Network combined)	$200 copay after deductible	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	$100 copay after deductible	50%
Other Outpatient Services (including but not limited to): • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services (Network/Non-Network combined) 100 visits (excludes IV Therapy) • Durable Medical Equipment, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	$20 copay after deductible 20% $15 copay after deductible 0% after deductible	50% 20% 50% 0% after deductible
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 60 visits • Occupational therapy: 60 Visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits • Cardiac Rehabilitation: unlimited • Pulmonary Rehabilitation: unlimited	$15 copay after deductible / $25 copay after deductible (Cardiac Rehabilitation)	50% 50%
Accidental Dental: $3,000 limit per accident (Network and Non-Network combined)	100% after deductible	100% after deductible
Behavioral Health Services **Mental Illness and Substance Abuse[1]:** • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	$200 copay after deductible $25/$25 copay after deductible	50%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	20%	50%

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Prescription Drug Options: National Formulary **Network Tier structure equals 1/2/3**		
• **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	$10/$40/$60	50%[3]
• **Home Delivery Service:** (90-day supply) Includes diabetic test strip	$20/$80/$120	Not covered
Member may be responsible for additional cost when not selecting the available generic drug. Members have additional cost with retail supply greater than 30 days.		
Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.		

Notes:

- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0% and to all listed with a copay.
- Dependent age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance or a copay, deductible and coinsurance apply to allergy injections. If billed separately, Network Allergy injections are subject to the Allergy Injection $25 copayment.
- Ambulance Non-network non-emergency use limited to $50,000 per benefit period.
- NCS (No Cost Share) means no deductible/copayment/coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Live Health Online (LHO) is covered at the PCP costshare.
- Benefit period = plan year
- Prosthetic limbs are unlimited and do not apply to a Plan Lifetime Maximum.
- Mammograms (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are no deductible/coinsurance up to the maximum allowable amount.
- Private Duty Nursing – limited to 35 visits per plan year.
- Elective abortions are covered unless otherwise noted in your Certificate of Coverage.

[1] We encourage you to review the Schedule of Benefits for limitations.
[2] Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
[3] Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: None

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 333-5735.

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(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 333-5735

Chinese
(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 333-5735

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French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 333-5735.

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5735.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5735

(Japanese) (日本語):
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Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5735 로 문의하십시오.

(Navajo) (Din4): D77 naaltsoos bik1'7g77 [ahgo b7na'7d7[kidgo n1 boh0n4edz3 d00 bee ah00t'i' t'11 ni nizaad k'ehj7 bee ni[hodoonih t'1adoo b33h 7l7n7g00. Ata' halne'7g77 [a' bich'8' hadeesdzih n7n7zingo koj8' hod77lnih (855) 333-5735.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 333-5735.

(Punjabi) (ਪੰਜਾਬੀ): *ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ,* (855) 333-5735 *ਤੇ ਕਾਲ ਕਰੋ।*

(Russian) (Русский): *если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 333-5735.*

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 333-5735.

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(TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html