Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: CUSTOM

Your School: INDIANA UNIVERSITY INTERNATIONAL PLAN

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$500 person / $1,500 family	$750 person / $2,250 family
Out-of-Pocket Limit	$3,000 person / $6,000 family	$3,000 person / $6,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits with Doctors who also provide services in person		
Primary Care (PCP)	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Specialist Care	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse Care	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Specialist Care	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Visits in an Office		
Primary Care (PCP)	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Specialist Care	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.*	No charge after medical deductible is met	50% coinsurance after medical deductible is met
Retail Health Clinic	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prescription Drugs - *Dispensed in the office*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	$50 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$100 copay per visit after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	$100 copay per visit after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees *Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Rehabilitation services *Coverage for Physical Therapy is limited to 60 visits per benefit period. Coverage for Occupational Therapy is limited to 60 visits per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.*		
Office	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Habilitation services *Coverage for Physical Therapy is limited to 60 visits per benefit period. Coverage for Occupational Therapy is limited to 60 visits per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.*		
Office	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	$25 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility)	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not Applicable	Not Applicable
Pharmacy Out of Pocket Limit	Combined with medical out-of-pocket limit	Combined with medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Select drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription (retail) and $20 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$40 copay per prescription (retail) and $80 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$75 copay per prescription (retail) and $150 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	$150 copay per prescription (retail) and $150 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
<u>Children's Vision Essential Health Benefits (up to age 19)</u> **Vision exam** *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Lenses *Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single* Reimbursed Up to $25*, Bifocal* Reimbursed Up to $40*, Trifocal* Reimbursed Up to $55*.*	No charge	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Limited to 2 visits per 12 months.*	No charge	No charge
Basic services	20% coinsurance dental deductible does not apply	20% coinsurance dental deductible does not apply
Major services	50% coinsurance dental deductible does not apply	50% coinsurance dental deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance dental deductible does not apply	50% coinsurance dental deductible does not apply
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
Adult Dental	Not covered	Not covered

Notes:

- 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.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=IN_SH_PPO.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Language Access Services:

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

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(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 .

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՝ :

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。

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره تماس بگیرید.

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 .

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 .

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 .

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih .

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: .

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 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. .

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang .

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi .

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (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.