Your Summary of Benefits

Anthem

Trine University
Blue Access® for Health Savings Accounts
Effective January 1, 2016

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits

Covered Benefits	Network	Non-Network
Embedded Deductible The single deductible does apply to family coverage	Single: $3,000 Family: $6,000	Single: $6,000 Family: $12,000
Out-of-Pocket Limit	Single: $5,000 Family: $10,000	Single: $10,000 Family: $20,000
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	20%	50%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	50%
Emergency and Urgent Care • **Emergency Room Services (facility/other covered services)** (copayment waived if admitted) • **Urgent Care Center Services**	20% 20%	20% 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	20%	50%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days for skilled nursing facility	20%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	50%
Blue 8.5		

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Other Outpatient Services (Network/Non-network combined) including but not limited to: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, Limbs and Medical Supplies) • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% 20% 20%	50% 20% 20%
Accidental Dental Services $3,000 limit per occurrence (network and non-network combined)	20%	50%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 20% 20%	 50% 50%
Behavioral Health Service **Mental Illness and Substance Abuse[1]:** • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional.	20%	50%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	20%	50%

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Prescription Drugs • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service. Medicare Rx - Wrap	20% 20%	50%[2] Not covered
Lifetime Maximum **(Combined Network and Non-network)[3]**	Unlimited	Unlimited

Notes:

- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance including 0%.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/coinsurance applies.
- Network and non-network deductibles, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26
- No cost share (NCS) means no deductible/copayment/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.
- Benefit period = calendar year
- Prosthetics Limbs are unlimited and do not apply to the Plan Lifetime Maximum.[4]
- 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 covered.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage

1 We encourage you to review the Schedule of Benefits for limitations.
2 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Once the RX deductible is met, the appropriate copayment applies. Also if applicable, the Prescription Drug out of pocket maximum applies to Network/Non-network Retail and Home Delivery-Service combined.

Rx Option K: Generic Premium uses a condensed preferred drug list. Non-preferred drugs are not covered. Requires Home Delivery service after 3rd fill at retail.

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.

This benefit overview is for illustrative purposes and some content may be pending Indiana Department of Insurance approval.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date