MEDICAL BENEFITS—ANTHEM BLUE ACCESS PPO NETWORK
Anthem National PPO (BlueCard PPO) network in other states, Anthem Blue Cross Blue Shield Global Core network overseas

Covered Charges: Up to the Maximum Allowable Amount that In-Network providers accept as payment in full. The member is responsible for amounts above Maximum Allowable Amounts when Out-Of-Network providers are used.

Pre-certification Requirements: Network providers are required to pre-certify all inpatient stays (except deliveries) and certain outpatient services, for example, high-cost procedures such as brain/spine MRIs, PET scans, and sleep studies. When a member receives services out-of-network, the member is responsible for pre-certifying services and any additional costs incurred by failure to pre-certify.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$500 individual / $1,000 family</td>
<td>$900 individual / $1,500 family</td>
</tr>
<tr>
<td>Medical Out-of-Pocket (OOP) Maximum</td>
<td>$2,400 individual / $7,200 family</td>
<td>$6,850 individual / $13,700 family</td>
</tr>
</tbody>
</table>

Ambulance Services (when Medically Necessary) 20% after deductible
No coverage unless an emergency

Emergency Room for Emergency Medical Condition $150 copay
Copay waived if admitted

Hearing Care
- Office visit-audiometric exam/hearing evaluation test
- Hearing Devices/Hearing Aids
  - Dependents under age 18 limit 1 per ear every 36 months
  - Adults age 18 & up max of $3,000 once every 5 years for one/both ears
20% after deductible
40% after deductible

Home Health Care Services
- Maximum 30 Out-of-Network home health care visits
- Private Duty Nursing only covered in the home
20% after deductible
40% after deductible

Hospice Care Services
No charge

Hospital Inpatient Services (Pre-certification required)
- Room and board (semiprivate or [CU/CCU])
- Hospital services & supplies (x-ray, lab, anesthesia, surgery [pre-certification required], etc.)
- Physician services (surgeon, anesthesiologist, etc.)
20% after deductible
40% after deductible
(maximum 60 physical medicine/rehabilitation days)

Maternity Care
Covered as any other medical condition. Subject to same deductibles, coinsurance, and maximums.

Medical Supplies & Equipment
- Medical supplies
- Durable medical equipment (DME)
- Prosthetic appliances (external)
20% after deductible
40% after deductible
(certain supplies may only be covered In-Network)

Outpatient Hospital/Facility Services
- Outpatient facility
- Lab and x-ray services
- Physician services (surgeon, anesthesiologist, etc.)
20% after deductible
40% after deductible

Physician Office Services
- Primary care (PCP) & Specialist visits/consultations
- Office surgery, telehealth, diagnostic services, allergy testing & treatment
- Prescription injectables/prescriptions dispensed in physician's office
20% after deductible
40% after deductible

Preventive Services
- Office Services (e.g. routine exams, well child visits, immunizations, labs, routine vision and hearing exams, pelvic exams, STI screenings)
- Hospital/Facility Procedures (e.g. screening colonoscopy, pap tests, mammograms, PSA test)
- Women's contraceptive services (e.g. IUDs, implanted and injectable hormones, and sterilization)
- $0 Covered at 100%—not subject to deductible
40% after deductible

Therapy Services (Outpatient)
Combined in- and out-of-network limits apply to:
- Physical/Occupational/Speech Therapy: 140 visits combined
- Manipulation Therapy: 12 visits
- Cardiac Rehabilitation: Unlimited
- Pulmonary Rehabilitation: Unlimited
20% after deductible
40% after deductible

Urgent Care Clinic Visit $75 copay
40% after deductible

1 In-Network and Out-Of-Network deductible, coinsurance, and maximums are separate and do not accumulate toward each other.
BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER
Many services (in- and out-of-network) must be preauthorized by Anthem Behavioral Health.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health &amp; Substance Use Disorder</td>
<td>Covered as any other medical condition. Subject to same deductibles, coinsurance, and maximums. Residential BH/SUD treatment covered as any other inpatient service.</td>
<td></td>
</tr>
</tbody>
</table>

HUMAN ORGAN & TISSUE TRANSPLANTS—BLUE DISTINCTION CENTERS FOR TRANSPLANTS

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants (Except kidney and cornea (covered as medical benefit))</td>
<td>Covered at 100% (see plan document for limits)</td>
<td>50% after deductible (does not count towards OOP max)</td>
</tr>
</tbody>
</table>

OUTPATIENT PRESCRIPTION DRUGS—CVS CAREMARK
Benefits are subject to certain prior authorization and quantity limit guidelines. Within the brand and generic categories, drugs are assigned a copay “tier” based on cost and therapeutic value to other drugs. Tier 1 drugs are generics; Tier 2 drugs are preferred brands; Tier 3 drugs are non-preferred brand drugs. Certain diabetic and asthmatic supplies are covered in full, but coverage is limited to in-network pharmacies only.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
<th>Limitations/Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Generic²)</td>
<td>Retail (30-day supply): $8</td>
<td>Mail Order (90-day supply): $20</td>
<td>50% coinsurance plus amounts above the network's discounted price</td>
</tr>
<tr>
<td>Tier 2 (Preferred Brand)</td>
<td>Retail (30-day supply): $25</td>
<td>Mail Order (90-day supply): $62</td>
<td>Out-of-Pocket limit for In-Network Prescriptions: • $6,700 individual • $11,000 family</td>
</tr>
<tr>
<td>Tier 3 (Non-Preferred Brand)</td>
<td>Retail (30-day supply): $45</td>
<td>Mail Order (90-day supply): $112</td>
<td>Mail Order only covered In-Network. Copays do not apply toward deductible.</td>
</tr>
<tr>
<td>Specialty Drugs (30-day supply³)</td>
<td>Tier 1 (Generic¹): $20 Tier 2 (Preferred Brand): $62 Tier 3 (Non-Preferred Brand): $112</td>
<td>No Coverage Coverage limited to In-Network Mail Order only.</td>
<td></td>
</tr>
</tbody>
</table>

VISION AND EYEWEAR—BLUE VIEW VISION
See separate summary for full benefit details.

<table>
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<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Eye Exam</td>
<td>$10 copay, no deductible</td>
<td>$42 allowance</td>
</tr>
<tr>
<td>Vision Wear</td>
<td>Specific allowances and discounts. Highest level of benefit in-network. Some enhancements are not covered out-of-network. See the separate summary for details.</td>
<td></td>
</tr>
</tbody>
</table>

PARTIAL LIST OF EXCLUSIONS
See the plan booklet for a full list of exclusions.

- Acupuncture
- Cosmetic surgery, procedures, and drugs.
- Dental care (Adult)
- Infertility treatment
- Custodial care, convalescent, or “long-term” nursing care.
- Private duty nursing in a hospital or skilled nursing facility.
- Supportive devices for the feet, and routine foot care.
- Routine eye care except as covered in Vision Benefit.
- Any service not medically necessary as determined by the Plan Administrator.
- Services and supplies for obesity or weight control, except surgery for morbid obesity.

¹ In-Network and Out-Of-Network deductible, coinsurance, and maximums are separate and do not accumulate toward each other.
² For a brand drug with a generic version available, members must pay the generic copay plus the cost difference between the brand and generic.
³ Specialty Drugs: High cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through mail order.
⁴ Medical expenses do not count toward the prescription out-of-pocket limit.

This is a plan summary. The entire provisions are contained in the Plan Booklet which can be obtained at hr.iu.edu/benefits. In the event of a conflict with this document, the terms of the Plan Booklet will prevail.