Anthem® Blue Cross and Blue Shield
Your Plan: CUSTOM
Your School: INDIANA UNIVERSITY PROFESSIONAL PLAN
Your Network: Blue Access

<table>
<thead>
<tr>
<th>Covered Medical Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Deductible</td>
<td>$350 person / $1,050 family</td>
<td>$700 person / $2,100 family</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>$5,000 person / $10,000 family</td>
<td>$5,000 person / $10,000 family</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Preventive Care / Screening / Immunization</th>
<th>No charge</th>
<th>50% coinsurance after medical deductible is met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virtual Care (Telemedicine / Telehealth Visits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virtual Visits with Doctors who also provide services in person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care (PCP)</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Care</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Virtual Visits from Online Provider LiveHealth Online via</strong>&lt;br&gt;<strong><a href="http://www.livehealthonline.com">www.livehealthonline.com</a>; our mobile app, website or Anthem-enabled device</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care (PCP) and Mental Health and Substance Abuse Care</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Visits in an Office</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care (PCP)</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Other Practitioner Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Maternity Care</strong> (Prenatal and Postnatal)&lt;br&gt;<em>In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Health Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manipulation Therapy <em>Coverage is limited to 12 visits per benefit period.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Services in an Office</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Chemo/Radiation Therapy</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Dialysis/Hemodialysis</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td><strong>Prescription Drugs - Dispensed in the office</strong></td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lab</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Freestanding Lab/Reference Lab</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>X-Ray</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Freestanding Radiology Center</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Advanced Diagnostic Imaging</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Freestanding Radiology Center</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td><strong>Emergency and Urgent Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$50 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Emergency Room Facility Services</strong></td>
<td>$100 copay per visit after medical deductible is met</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td><strong>Emergency Room Doctor and Other Services</strong></td>
<td>$100 copay per visit after medical deductible is met</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>20% coinsurance after medical deductible is met</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td><strong>Outpatient Mental/Behavioral Health and Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor Office Visit</strong></td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Facility Visit</strong></td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Facility Fees</strong></td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Doctor Services</strong></td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility Fees</strong></td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Freestanding Surgical Center</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Doctor and Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Freestanding Surgical Center</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Fees&lt;br*&lt;span style=&quot;text-align: justify;&quot; &gt;Benefit includes coverage for Outpatient Rehabilitation program.&lt;/span&gt;</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Human Organ and Tissue Transplants&lt;br*&lt;span style=&quot;text-align: justify;&quot; &gt;Coverage includes acquisition and transplant procedures, collection and storage.&lt;/span&gt;</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Doctor and other services</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Recovery &amp; Rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care&lt;br*&lt;span style=&quot;text-align: justify;&quot; &gt;Coverage is limited to 100 visits per benefit period.&lt;/span&gt;</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong>&lt;br*&lt;span style=&quot;text-align: justify;&quot; &gt;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.&lt;/span&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td><strong>Habilitation services</strong>&lt;br*&lt;span style=&quot;text-align: justify;&quot; &gt;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.&lt;/span&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Office</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$25 copay per visit after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Skilled Nursing Care (facility)</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Inpatient Hospice</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>20% coinsurance after medical deductible is met</td>
<td>50% coinsurance after medical deductible is met</td>
</tr>
</tbody>
</table>

*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*
## Covered Prescription Drug Benefits

<table>
<thead>
<tr>
<th>Covered Prescription Drug Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Deductible</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Pharmacy Out of Pocket Limit</td>
<td>Combined with medical out-of-pocket limit</td>
<td>Combined with medical out-of-pocket limit</td>
</tr>
</tbody>
</table>

### 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.*

#### 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

<table>
<thead>
<tr>
<th>Covered Vision Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
</table>

*This is a brief outline of your vision coverage. Only children’s vision services count towards your out of pocket limit.*

### Children’s Vision Essential Health Benefits (up to age 19)

#### 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
<table>
<thead>
<tr>
<th>Covered Vision Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lenses</strong> &lt;br&gt; 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.</td>
<td>No charge</td>
<td>Receives Reimbursement</td>
</tr>
<tr>
<td><strong>Elective Contact Lenses</strong> &lt;br&gt; Limited to 1 unit per benefit period.</td>
<td>No charge</td>
<td>Reimbursed Up to $60</td>
</tr>
<tr>
<td><strong>Non-Elective Contact Lenses</strong> &lt;br&gt; Limited to 1 unit per benefit period.</td>
<td>No charge</td>
<td>Reimbursed Up to $210</td>
</tr>
<tr>
<td>Covered Dental Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Dental Essential Health Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and preventive</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Limited to 2 visits per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic services</td>
<td>20% coinsurance dental deductible does not apply</td>
<td>20% coinsurance dental deductible does not apply</td>
</tr>
<tr>
<td>Major services</td>
<td>50% coinsurance dental deductible does not apply</td>
<td>50% coinsurance dental deductible does not apply</td>
</tr>
<tr>
<td>Medically Necessary Orthodontia services</td>
<td>50% coinsurance dental deductible does not apply</td>
<td>50% coinsurance dental deductible does not apply</td>
</tr>
<tr>
<td>Cosmetic Orthodontia services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Deductible</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Adult Dental</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
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.
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)
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.