

Blue Preferred Primary POS — Benefit Summary

This is a plan summary. The entire provisions of benefits and exclusions are contained in the Certificate and Schedule of Benefits which can be obtained at www.indiana.edu/~uhhs/benefits. If you would like a hard copy of this booklet mailed to you, please contact the UHRS Publications Coordinator at (812) 855-2985. In the event of a conflict with this document, the terms of the Certificate and Schedule of Benefits will prevail.

Medical Benefits — Anthem Blue Preferred Primary Network

| Service | In-Network Provider - Member Pays | Out-of-Network Provider - Member Pays* |
|---|--|--|
| Medical Annual Deductible | None | \$500 per person/\$1,000 per family |
| Covered Charges | Up to the Usual & Reasonable (U&R) amount that In-Network providers accept as payment in full under their Anthem participation agreement. The member is responsible for amounts above U&R reimbursements when Out-of-Network providers are used. | |
| Medical Out-of-Pocket Maximum (All copays and deductibles, except prescription drug and human organ transplants, apply toward this maximum) | \$2,000 (\$5,000 family)** | \$4,000 (\$10,000 family)** |
| Physician Office Services <ul style="list-style-type: none"> • Primary, specialist visits/consultations • Labs, x-ray, and allergy services billed by the physicians office. | \$25 copay per visit | 30% after deductible. |
| Wellness/Preventive Services <ul style="list-style-type: none"> • Routine exams, pap tests, well child visits, immunizations, mammograms, routine and annual diabetic eye exams, hearing exams, and other screenings. | \$25 copay per office visit (Immunizations and mammograms have no copay when rendered without an office visit) | 30% after deductible. |
| Hospital Outpatient Services <ul style="list-style-type: none"> • Physician Services • Facility Services | No copay \$100 per visit | 30% after deductible. |
| Hospital Inpatient Services <ul style="list-style-type: none"> • Physician and Ancillary Services • Facility Services | No copay \$250 per visit | 30% after deductible. (Maximum of 60 Physical Medicine/ Rehabilitation Days) |
| Maternity Services | Covered as any other medical service. | |
| Emergency Room for Emergency Care | \$100 copay (no coverage unless an emergency) | |
| Urgent Care Facility | \$40 copay | |
| Durable Medical Equipment (DME), Medical Supplies and Appliances | 20% copay | 40% copay on DME after deductible. (Certain supplies may only be covered In-Network) |
| Therapy: Physical, Occupational, Speech Maximum visits per benefit year (combined In- and Out-of-Network) Physical/Occupational - 30 visits Speech - 20 visits Spinal Manipulations - 12 visits | \$25 copay per visit | 30% after deductible. |
| Home Health Care | No copay | 30% after deductible. (30-day maximum) |
| Vision / Hearing Exams (Preventive only) | \$25 copay | 30% after deductible. |

* It is important to note that the medical plan does NOT guarantee that all covered services will be available through In-Network providers. If an In-Network provider is not available, the service will be processed as an Out-of-Network expense, except in an emergency or when an Out-of-Network provider renders service while the member is an inpatient or outpatient in an In-Network facility. However, in any case, the member is responsible for amounts above maximum allowable charges.

** In-Network and Out-of-Network copays, deductibles, and maximums are separate and do not accumulate toward each other.

Medical Benefits (continued)

Precertification Requirements

- Network providers are required to precertify all inpatient stays (except deliveries) and certain outpatient services, for example:
- Hysterectomy
 - Septoplasty/Rhinoplasty
 - Pediatric therapies
 - High-cost procedures, such as brain/spine MRIs, PET scans, sleep studies
 - Mastectomy/Reconstructive surgery
 - DME/Prosthetics
 - Hospice and home health care

Mental Health and Substance Abuse - Anthem Behavioral Health

All services, both In- and Out-of-Network, must be preauthorized by Anthem Behavioral Health.

| Service | In-Network Provider - Member Pays | Out-of-Network Provider - Member Pays |
|--|--|---------------------------------------|
| Mental Health and Substance Abuse | Covered as any other illness; subject to same copays, deductibles and maximums | |

Organ and Tissue Transplants - Blue Quality Centers for Transplants

(Does not count toward out-of-pocket maximum)

| Service | In-Network Provider - Member Pays | Out-of-Network Provider - Member Pays |
|---|---|---|
| Transplants (except kidney and cornea covered as medical benefit) | No copay (see plan document for limits) | 50% copay after deductible. (does not count towards out-of-pocket maximum) |
| Lifetime Maximum | \$2,000,000 Lifetime Maximum Benefit per member | |

Outpatient Prescription Drug - Anthem Prescription Retail Network/NextRx Mail Order

Benefits are subject to certain prior authorization and quantity limit guidelines. Benefits do not count toward the out-of-pocket maximum. Certain diabetic and asthmatic supplies are covered in full but coverage is limited to network pharmacies only.

| Service | In-Network Provider - Member Pays | Out-of-Network Provider - Member Pays |
|--|---|---|
| Retail Prescriptions (up to 30-day supply) | <ul style="list-style-type: none"> • No deductible • \$8 formulary generic R_x • \$20 formulary brand R_x • \$40 non-formulary R_x • Noncovered w/network discount - 100% | 50% copay, plus amounts above the network's discounted price. |
| Mail Order Prescriptions (up to 90-day supply) | <ul style="list-style-type: none"> • No deductible • \$20 formulary generic R_x • \$45 formulary brand R_x • \$90 non-formulary R_x • Noncovered w/network discount - 100% | Not covered. |

Partial List of Exclusions (Complete list in Plan Booklet)

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| <ul style="list-style-type: none"> • Any service not medically necessary as determined by the Plan Administrator. • Custodial care, convalescent, or "long-term" nursing care. • Cosmetic surgery, procedures, and drugs. • Services, supplies, and drugs for obesity or weight control, except surgery for morbid obesity. • Radial keratotomy or similar procedures. • Eyeglasses or contact lenses, except in aphasic patients and soft lenses or sclera shells for use as corneal bandages. • Supportive devices for the feet, and routine foot care. • Immunizations and exams required for enrollment in an insurance program, as a condition of employment, for licensing, or for other purposes such as camps or travel. • Experimental/Investigative services. | <ul style="list-style-type: none"> • Artificial insemination; fertilization (such as in-vitro, GIFT, ZIFT) or procedures and testing related to fertilization; reversal of sterilization; infertility drugs and related services following the diagnosis of infertility. • Drugs, devices, or services related to sex transformation, male or female sexual or erectile dysfunction or inadequacy regardless of the cause. • Over-the-counter drugs; drugs not FDA approved. • Drugs in excess of limits established by the plan. • Non-sedating (3rd generation) antihistamines, such as Zyrtec and Allegra. • Services for which coverage is provided by or required by law by a public/ governmental agency, facility, or program. • Services and supplies used to treat conditions to the extent that, according to generally accepted Professional Standards, such conditions are not amenable to favorable modification through medical treatment. |
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