INDIANA UNIVERSITY HEALTH

Health and Welfare Benefit Plan

Summary Plan Description

Administered by IU Health Plans

Health Plans

Summary Plan Description

Your Guide to Quality Healthcare Services and Healthier Living. As an employee of Indiana University Health, this document is to help you understand the healthcare services and benefits available to you and your dependents and will be updated as necessary.

This Summary Plan Description is a SPD. We encourage you to take the time to read it carefully and to access it for future reference. Plan information is available on the IU Health Plans website: myiuhealthplans.com

You will find helpful information about:

- Network Providers;
- Covered benefits and services, limitations and exclusions;
- Administrative and enrollment procedures;
- The medical benefits administrator and coordination of benefits;
- Medical Management services to ensure quality care;
- The Prescription Drug benefit and eligibility;
- Pharmacy and benefits management programs; and
- Member services.

Refer to this document for detailed information and definitions of the terms used throughout the Plan. Be sure to bookmark this document for quick reference when you need it. If you have any questions, contact IU Health Plans Member Services for information: 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday or visit our website at: iuhealth.org.

This is your guide to quality healthcare services and healthier living. Quality healthcare is everybody's responsibility. We encourage you to pursue a lifestyle of healthy living. IU Health Plans looks forward to assisting you with your healthcare needs.

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Section One:

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE SUMMARY PLAN DESCRIPTION

THIS SUMMARY PLAN DESCRIPTION ("SPD"), made by **Indiana University Health, Inc.** (the "Company" or the "Plan Sponsor") as of January 1, 2017, hereby sets forth the provisions of the Indiana, Inc. Health and Welfare Benefit Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

THIS SUMMARY PLAN DESCRIPTION ("SPD"), made by **Indiana University Health, Inc.** (the "Company" or the "Plan Sponsor") as of January 1, 2017, hereby **amends and restates** the Indiana University Health, Inc. Health and Welfare Benefit Plan (the "Plan"), which was originally adopted by the Company to be effective January 1, 2017. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The SPD is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

Adoption of the SPD

The Plan Sponsor, as the settlor of the Plan, hereby adopts this SPD as the written description of the Plan. This SPD represents the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This SPD amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this SPD to be executed.

Indiana University Health, Inc.

By: _____

Name: _____

Date: _____ Title: _____

Section Two:

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Covered Persons and/or the Plan Sponsor, or are funded solely from the general assets of the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Employer's general assets. Covered Persons in the Plan may be required to contribute toward their benefits. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the SPD, to allow the Plan Sponsor to effectively assign the resources available to help Covered Persons in the Plan to the maximum feasible extent.

The Plan Sponsor is required under ERISA to provide to Covered Persons a Summary Plan Description. The Plan Sponsor has adopted this SPD as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The SPD is maintained by the **Indiana University Health, Inc.** and may be reviewed at any time during normal working hours by any Covered Person.

General Plan Information

Name of Plan:	**Indiana University Health, Inc. Health and Welfare Benefit Plan**
Plan Sponsor:	**Indiana University Health, Inc.** **340 W. 10th Street** **Indianapolis, Indiana 46202**

Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**ERISA**
Plan Year:	**January 1, 2017- December 31, 2017**
Plan Number:	**508**
Plan Type:	**Medical** **Prescription Drug**
Administrative Services Only (ASO):	
Agent for service of Process:	**IU Health Plans** **950 N. Meridian St., Ste. 200** **Indianapolis, IN 46204** **Phone: (800) 873-2022** **Fax: (317) 963-9800** **Website: www.iuhealth.org**

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This SPD and any amendments constitute the terms and provisions of coverage under this Plan. The SPD is not to be construed as a contract of any type between the Company and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee.

Mental Health Parity

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and any regulations promulgated there under collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Sponsor shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan.

Section Three:

PLAN CHOICES AND NETWORKS

In 2017, Indiana University Health Employees will have 4 medical Plan options to choose from.

HSA Medical Plan and HSA Medical Saver Plan

The HSA medical Plans provide lower premiums for Team Members willing to accept potentially higher out-of-pocket costs for their care. IU Health is among the increasing number of large Employers offering this type of Plan.

HSA Plans allow Team Members to contribute funds to a personal Health Savings Account (HSA) on a pre-tax basis, which can be used to pay for eligible medical expenses until the Deductible/Out-of-Pocket Maximum is met. Employers are also allowed to make contributions to Team Member's HSA accounts. IU Health will make a "pre-funded" Employer contribution to Participating Team Member's HSA accounts at the beginning of 2017. The contribution amount will depend on whether a Team Member selects the "Employee Only" (Individual) coverage option or the "Family" (Employee & Child; Employee & Spouse, Employee & Family) coverage option. IU Health will make this contribution even if a Team Member decides not to contribute to his or her own HSA.

A Team Member enrolled in an HSA medical Plan is responsible for paying the full cost of services for themselves and their enrolled Dependents, including prescriptions—with the exception of specific qualified preventive care services and preventive prescriptions—until the annual HSA Plan Deductible is met. Once the Deductible is met (Note: if enrolled at the family coverage level—Employee & Spouse, Employee & Children or Employee & Family, you must meet the full family Deductible), the Plan begins to pay Coinsurance based on where the services are received. (Coinsurance is a cost sharing feature in which the Team Member and the health Plan each pay a certain percentage of the cost of care until the Team Member's Out-Of-Pocket Maximum is reached.)

Contributions to HSAs are limited by federal regulations. The limits for 2017, which include both Team Member and Employer contributions, are $3,400 for individuals and $6,750 for families. Unused HSA funds roll over from year to year and stay with the individual through retirement, even if the individual should leave IU Health or no longer participate in the Plan. Unlike a traditional healthcare flexible spending account (FSA), unused HSA balances are not lost at the end of the year. This provides individuals the opportunity to accumulate funds for future qualified expenses. HSA funds can also be invested for the possibility of greater earning potential.

Optum Bank will administer the HSA accounts. Team Members enrolling in one of the HSA medical Plans will be asked to read the updated Optum Bank Custodial Agreement via a USPS introductory mailing. There are no claim forms with an HSA. Participating Team Members will receive a debit card to pay for qualified medical expenses, such as prescriptions, doctor's fees or

exams. Payment can also be made by logging into the optumbank.com website or by calling their 24/7 customer service line at 1.844.326.7967. Checks may be ordered upon request.

Per federal regulations, HSA Plan members are not eligible for enrollment in another Plan (such as, Medicaid, Medicare Part A or TriCare) and may not participate in a traditional healthcare flexible spending account (FSA). A "limited-purpose FSA" is available to pay for eligible, non-reimbursed dental and vision costs. For general information about the HSA (including a complete listing of HSA-qualified expenses), please visit optumbank.com.

Contact your local benefits office for more information on HSAs.

Traditional PPO Medical Plan

The Traditional PPO Medical Plan provides copayments for Medical Care and prescriptions that count towards the Out-of-Pocket Maximum. Deductible, Coinsurance and Out-of-Pocket Maximums are based on where services are received.

A Team Member enrolled in the Traditional PPO medical Plan is responsible for paying Copayments and Coinsurance once the Deductible is met for themselves and their enrolled Dependents with the exception of specific qualified preventive care services. Once the Deductible is met, the Plan begins to pay Coinsurance based on where the services are received. (Coinsurance is a cost sharing feature in which the Team Member and the health Plan each pay a certain percentage of the cost of care until the Team Member's Out-Of-Pocket Maximum is reached.)

HRA Medical Plan

The Health Reimbursement Arrangement (HRA) Medical Plan provides lower premiums for team members willing to accept higher out-of-pocket costs for their care but want to have a sense of financial security.

HRA plans are employer-sponsored accounts that help plan participants pay for medical expenses incurred before deductibles are met (the deductible is reduced--to $0 once the HRA credit is applied--for full-time team members in salary Tier 1, if the care is provided by an IU Health provider or facility). The IU Health HRA plan offers advantages similar to the HSA-based plans (deductible, coinsurance and out-of-pocket maximum amounts are the same), but is especially suitable for team members 65 or older on Medicare plans, military insurance plans and other types of coverage that precludes them from receiving IU Health HSA contributions or depositing pre-tax dollars to an HSA account.

The HRA plan also has some aspects of the traditional PPO plan—it offers copays for pharmacy expenses and individual deductibles.

Team members enrolled in the HRA Medical Plan are responsible for paying the full cost of services for themselves and their enrolled dependents prior to meeting the deductible—with the exception of eligible pharmacy expenses and specific qualified preventive care services—

but they will receive an IU Health credit toward the deductible. Note: The HRA credit does not apply toward pharmacy expenses. The pharmacy copay/coinsurance does not apply to the deductible, but does apply toward the out-of-pocket maximums.

The amount of the IU Health HRA credit will depend upon whether the team member selects the "Employee Only" coverage option or one of the family options (Employee and Spouse/Domestic Partner, Employee and Child(ren) or Family):

- $700 (Employee Only coverage)
- $1,400 (Family coverage)

Unlike the HSA-based plans, team members are not eligible to contribute pre-tax dollars to their HRA. However, HRA plan participants are eligible to enroll in the traditional health care flexible spending account to set aside pre-tax dollars to pay for eligible medical, dental and/or vision expenses.

The HRA credit is available at the beginning of 2017. Remaining balances carry over from year to year (up to a maximum of $5,000) and may be accessed as long as you continue to be enrolled in the IU Health HRA Medical Plan.

Team members enrolling in the IU Health HRA Plan will be automatically enrolled in Accident and Critical Illness plans, paid for by IU Health. The Accident and Critical Illness plans help offset the HRA Medical plan deductible and out-of-pocket expenses related to an accident or critical illness. This, along with the IU Health HRA credit, will help reduce the financial burden of expenses.

Networks When Out of the Service Area

If an urgent medical problem occurs outside the State of Indiana, you may call PHCS/MulitPlan network at 800.922.4362 to find a participating provider.

If a life-threatening Emergency occurs, no matter where you are, call 911 for immediate help or go to the nearest medical Facility for treatment. Remember to advise your Primary Care Physician (PCP) for coordination of follow-up care.

Provider Directories

The most up-to-date listing of Network Providers, Physicians, Hospitals, and affiliated Facilities is available through the IU Health Plans website: myiuhealthplans.com. Be sure to check the Provider directory listings of Physicians and Facilities before services are obtained as the list changes from time to time. If you do not have regular access to a computer, contact IU Health Plans Member Services, 800.873.2022 or 317.816.5170 and a member services representative will assist you.

Section Four:

HEALTHCARE COVERAGE

The Plan is committed to providing comprehensive healthcare coverage for all Covered Persons. The portion the Covered Person pays for health coverage through premium deduction and out-of-pocket costs differs substantially based on the Plan you select.

The medical benefits through Indiana University Health Employee Benefits Plan are administered by IU Health Plans. IU Health Plans Member Services may be contacted at 800.873.2022 or 317.816.5170.

IU Health Plans encourages each Covered Person to develop a relationship with a Primary Care Physician (PCP). Physician specialties considered primary include: Family Practice, General Practice, Internal Medicine, and Pediatrics for Dependents 18 years and younger. This will provide you with the advantage of having a Physician knowledgeable about your healthcare needs who can provide:

- Preventive healthcare services;
- Care if you become ill;
- Advice regarding the need to see a Specialist.

With a PCP, your care is coordinated by one Physician and you can be assured that you are receiving the best possible healthcare available.

Network Providers

A Network Provider is a Physician, Hospital, Facility or ancillary service Provider who has an agreement with the Network to accept a reduced rate (Negotiated Rate) for providing Covered Services to Covered Persons. Because the Covered Person and the Plan save money when services, supplies or treatment are obtained from Providers Participating in the Network, benefits are usually greater than those available when using the services of a Non-Network Provider. A complete list of Network Providers is available on the IU Health Plans website: iuhealth.org in the provider directory section.

Referrals to Network Specialists for Covered Services are not required. However, coverage is subject to applicable Copayments, Coinsurance and Deductibles. Remember to advise your Primary Care Physician about services received from a Specialist so he/she can maintain your complete medical record.

The Network Provider may bill the Covered Person in the following instances:

1. Coinsurance amounts as reported on the Explanation of Benefits (based on the applicable percentage of the reimbursement to providers), Copayments and Deductibles as reported on the Explanation of Benefits;
2. Penalties imposed on a Covered Person by the Plan for the Covered Person's failure to comply with utilization management processes;

3. Services which are determined not to be Medically Necessary;
4. Non-Covered Services; and
5. Services for which the Plan fails to pay within the time for payment as set forth in the Network agreement or according to state law. (See Claims section for additional information.)

Network Providers may NOT bill the Covered Person in the following instances:

1. In the provision of Medically Necessary Covered Services, except Copayments, Deductibles and Coinsurance;
2. The difference between a Network Provider's billed charges and the Plan's Negotiated Rate;
3. For penalties imposed on Network Providers by insurers as a result of the Network Provider's failure to comply with the Plan's procedures of utilization management, after all final Appeals have been exhausted.

Non-Network Providers

A Non-Network Provider does not have an agreement with the Network Provider Organization and has not agreed to the Negotiated Rate when providing Covered Services. With Non-Network Providers, the Plan pays a lower amount than for Network Providers. The Plan uses only the Customary and Reasonable amount as the fee for the Covered Service, supply or treatment. The Covered Person may be billed for the remainder of billed charges by the Non-Network Provider. Deductibles and Coinsurance also apply.

Balance-Billing

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance-billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Covered Person is responsible for any applicable payment of co-insurances, Deductibles, out-of-pocket maximums and non-covered services and may be billed for any or all of these.

Referrals

Referrals are not needed to see a Provider for Covered Services. It is the Covered Person's responsibility to ensure services are performed by Network Providers to receive the highest level of payment for Covered Services. The following list of exceptions includes services, supplies or treatments provided by a Non-Network Provider that will be covered as if provided by a Network Provider:

- Non-Network anesthesiologist if the operating Facility is a Participating Provider.
- Radiologist or pathologist services for interpretation of x-rays and laboratory tests provided by a Non-Network Provider when the Facility participates in the Network.
- While confined to a Network Hospital, the Network Physician requests a consultation from the Non-Network Provider.
- Medically Necessary services, supplies and treatments not available through any Network Provider.
- Ambulance services.
- Non-Network assistant surgeon charges if the operating surgeon is a Network Provider.
- Urgent Care treatment.
- Emergency treatment at a Network Facility by a Non-Network Provider. If the Covered Person is admitted to the Hospital after such Emergency treatment, Covered Services shall be payable at the Network Provider level.

Benefits

This section provides a thorough explanation of benefits, including Behavioral Health benefits. Behavioral Health includes Mental Health and Chemical Dependency services. Note that Covered Services must be Clinically Appropriate and are subject to coverage limits and exclusions.

Indiana University Health has the right to review all claim reimbursements retrospectively and adjust payment according to its guidelines. This means the Covered Person may be financially accountable for services after they have been rendered.

The Summary of Benefits chart that follows summarizes coverage levels, Deductibles, Copayments, Coinsurance, Out-of-Pocket Maximum information and limits to Covered Services. Further explanation of benefits coverage, exclusions and limitation appear after the chart.

Summary of Benefits

Medical Benefits

The Plan pays the percentage listed on the following pages for Covered Charges Incurred by a Covered Person during the calendar year after the individual or family Deductible has been satisfied and until the individual or family Out-of-Pocket Maximum has been reached, except for Covered Preventive Care services. Thereafter, the Plan pays 100 percent (100%) of Incurred Covered Charges for the remainder of the calendar year or until the Maximum Benefit has been reached (where applicable).

All services are subject to Deductible unless otherwise indicated.

Services of Non-Network Physicians or Facilities unless due to a medical Emergency or with a Plan-approved referral are payable at a reduced rate. The Plan uses only the Customary and Reasonable amount as the fee for the Covered Service, supply or treatment when utilizing Out-of-Network Providers. The Covered Person may be billed for the remainder of billed charges by the Non-Network Provider. Deductibles and Coinsurance also apply.

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
Provider Networks Plan approved referrals are required for payment of certain services. See Prior Authorization listing.	**IU Health Plans** **Encore/PHCS** **Out-of-Network**	**IU Health Plans** **Encore/PHCS** **Out-of-Network**	**IU Health Plans** **Encore/PHCS** **Out-of-Network**	**IU Health Plans** **Encore/PHCS** **Out-of-Network**
Annual Deductible Individual/Family (Calendar Year) *Deductible waived for in Network services for Team Members whose full-time base pay in 2017 is equal or less than $34,063.23	**IU Health Plans** = $1,500/$3,000 **Encore/PHCS** = $2,000/$4,000 **Out-of-Network** = $2,500/$5,000	**IU Health Plans** = $2,000/$4,000 **Encore/PHCS** = $2,500/$5,000 **Out-of-Network** = $3,000/$6,000	**IU Health Plans** = $600/$1,200* **Encore/PHCS** = $1,200/$2,400 **Out-of-Network** = $1,200/$2,400	**IU Health Plans = $1,500/$3,000** **Encore/PHCS = $2,000/$4,000** **Out-of-Network = $2,500/$5,000**
Coinsurance (Chart shows Team Member responsibility)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Annual Out-of-Pocket Maximum	**IU Health Plans** = $3,750/$7,500*	**IU Health** Plans = $4,250/$8,500*	**IU Health** Plans = $3,750/$7,500**	**IU Health Plans =** $3,750/$7,500*

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
(OOPM) (Calendar Year) *Includes Deductible and Coinsurance **Includes Copays, Deductible and Coinsurance	**Encore/PHCS** = $5,500/$11,000* **Out-of-Network** = $6,500/$13,000*	**Encore/PHCS** = $6,250/$12,500* **Out-of-Network** = $7,500/$15,000*	**Encore/PHCS** = $5,500/$11,000** **Out-of-Network** = $6,500/$13,000**	**Encore/PHCS =** $5,500/$11,000* **Out-of-Network =** $6,500/$13,000*
Annual Copay Limit for Advanced Imaging, Inpatient and Outpatient Hospital Surgery/procedure (Calendar Year)	**N/A**	**N/A**	**N/A**	**N/A**
Allergy Testing	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 100%** after $35 Copay **Encore/PHCS = 100%** after $35 Copay **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Serums (Subject to Deductible and Coinsurance)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans =** 90% (after Deductible satisfied) **Encore/PHCS =** 70% (after Deductible satisfied) **Out-of-Network =** 50% (after Deductible)
Injections	**IU Health = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**100%**	**IU Health = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
Ambulance	**90%** (after Deductible satisfied)	**80%** (after Deductible satisfied)	**100%** (Deductible waived)	**90% (after Deductible satisfied)**
Behavioral/Mental Health and Chemical Dependency - Outpatient (Includes ABA therapy)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Chiropractic Care (1 initial or follow up visit and 12 per manipulations per calendar year)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health** Plans = **100%** after $35 Copay **Out-of-Network = $50** allowance after $35 Copay	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
CVS MinuteClinic (covered locations only)	**90%** (after Deductible satisfied)	**80%** (after Deductible satisfied)	**100%** after $20.00 Copay	**90%** (after Deductible satisfied

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
Diagnostic X-rays & Lab Services				
Diagnostic X-rays & Lab (per scan type per day)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Advanced Imaging Services (MRI, PET, CT, MRA, CTA, SPECT) (Per scan type per day)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Other	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Durable Medical Equipment (Rental or purchase whichever is less costly)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
Emergency Room Services *(Copay waived if admitted) Must be Medically Necessary for coverage	**90%** per incident (after Deductible is satisfied)	**80%** per incident (after Deductible is satisfied)	**100% after $200 Copay** per incident*	**90%** per incident (after Deductible is satisfied)
Extended Care Facility	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Home HealthCare	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Hospice Care	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Hospital Inpatient Hospital (includes Mental Health/Chemical Dependency)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
Hospital **Outpatient Hospital** (includes Mental Health/Chemical Dependency)				
Surgery/Procedures	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied) **IU Health Plans = 80%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Other Services	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Physician's Services				
Primary Care Office Visit (Primary Care means a Family Practitioner, Internal Medicine, General Practitioner, Pediatrician, Nurse Practitioner, Physician's Assistant and Mental Health Provider.)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 100%** after $20 Copay* **Encore/PHCS = 100%** after $20 Copay ***** **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
*Copays do not apply toward the Deductible Specialist Office Visit	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 100%** after $35 Copay* **Encore/PHCS =** 100% after $35 Copay***** **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
Inpatient & Home Visits	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Surgery—Inpatient	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Pathology	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Anesthesiology	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Radiology	**IU Health Plans = 90%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied)	**IU Health Plans =80%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied)

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
	Encore/PHCS = 70% (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Refractive Vision Exam* Eyemed Provider or Network contracted provider (1 per calendar year) Non-Eyemed or non-contracted Provider (1 per calendar year) *Not associated with the UnitedHealthcare vision Plan	**100%** after $35.00 Copay **$50.00** allowance	**100%** after $35.00 Copay **$50.00** allowance	**100%** after $35.00 Copay **$50.00** allowance	**100%** after $35.00 Copay **$50.00** allowance
Preventive Care Services	**IU Health Plans = 100%** **Encore/PHCS = 100%** **Out-of-Network = 50%**	**IU Health Plans = 100%** **Encore/PHCS = 100%** **Out-of-Network = 50%**	**IU Health Plans = 100%** **Encore/PHCS = 100%** **Out-of-Network = 60%**	**IU Health Plans = 100%** **Encore/PHCS = 100%** **Out-of-Network = 50%**
Prosthetics	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Temporomandibular Joint Dysfunction	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
Therapy Services **Physical /Occupational Therapy** (*Combined 60 visit limit per calendar year)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 100%** after $35 Copay **Encore/PHCS = 100%** after $35 Copay **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Speech (*20 visit limit per calendar year) * Visit limits for physical, occupational and speech therapy are not applicable to Pervasive Development Disorder Services.	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 100%** after $35 Copay **Encore/PHCS = 100%** after $35 Copay **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Transplants	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)
Urgent Care Center	**90%** (after Deductible satisfied)	**80%** (after Deductible satisfied)	**100%** after $20.00 Copay	**90%** (after Deductible satisfied)
Well Child Care & Immunizations (Deductible waived for in-Network services)	**IU Health Plans = 100%** **Encore/PHCS = 100%** **Out-of-Network = 50%**(after Deductible satisfied)	**IU Health Plans = 100%** **Encore/PHCS = 100%** **Out-of-Network = 50%**(after Deductible satisfied)	**IU Health Plans = 100%** **Encore/PHCS = 100%** **Out-of-Network = 50%**(after Deductible satisfied)	**IU Health Plans = 100%** **Encore/PHCS = 100%** **Out-of-Network = 50%**(after Deductible satisfied)

Medical Benefit Description	HSA Medical Plan	HSA Medical Saver Plan	Traditional PPO Medical Plan	HRA Medical Plan
All Other Covered Expenses	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 80%** (after Deductible satisfied) **Encore/PHCS = 60%** (after Deductible satisfied) **Out-of-Network = 40%** (after Deductible satisfied)	**IU Health Plans = 90%** (after Deductible satisfied) **Encore/PHCS = 70%** (after Deductible satisfied) **Out-of-Network = 50%** (after Deductible satisfied)

Note: Paoli utilizes the Southeastern Indiana Health Organization provider Network.

Deductible Information for HSA Medical Plan, HSA Saver Plan

For Individual coverage, the Covered Person must meet the individual Deductible before Coinsurance is applied. For Family coverage, the entire Family annual Deductible must be met before Coinsurance is applied for any individual family member.

Deductible Information for Traditional PPO Medical Plan and HRA Medical Plan

For individual coverage, the Covered Person must meet the individual Deductible before Copay or Coinsurance is applied. In a family of two Covered Persons, the second Covered Person must meet the individual Deductible to meet the overall family Deductible. With family coverage for a family of three or more individuals, the Deductible can be met by aggregating amounts, however, if one Covered Person reaches the individual Deductible, future Covered Services contribute to Coinsurance and the Out-of-Pocket Maximum.

Pharmacy Benefits

The Covered Person pays the Copay or Coinsurance (Coinsurance is a percentage rather than flat Copay amount) listed on the following pages for Covered Charges Incurred by a Covered Person during the calendar year until the individual or family out-of-pocket expense limit has been reached. Thereafter, the Plan pays 100 percent (100%) of Incurred Covered Charges for the remainder of the calendar year.

<table>
<tr><th></th><th>Preferred In-Network:
IU Health, CVS, Kroger/Payless</th><th>Non-Preferred
In-Network:</th></tr>
<tr><td colspan="3">HSA Medical Plan and HSA Medical Saver Plan
Member Cost Per Prescription* **</td></tr>
<tr><td>Tier 1 –
Generic (preferred)</td><td rowspan="4">20% of the prescription cost
(after Deductible satisfied – member pays 100% until the Deductible is met)

90-day max supply
(30-day max supply for tier 5 medication)</td><td rowspan="3">30% of the prescription cost
(after Deductible satisfied – member pays 100% until the Deductible is met)

30-day max supply</td></tr>
<tr><td>Tier 2 –
Generic</td></tr>
<tr><td>Tier 3 –
Brand (preferred); select generics</td></tr>
<tr><td>Tier 4 –
Brand (non-preferred); generics (non-preferred)</td></tr>
<tr><td>Tier 5 –
Specialty; Biotech medications (available only at IU Health Retail/Mail Pharmacies)</td><td>N/A</td></tr>
<tr><td>Mail Order</td><td>Yes; through IUH Mail Order,
same Coinsurance as above</td><td>N/A</td></tr>
<tr><td>Preventive Medications</td><td>Yes; $0 Copay</td><td>Yes; $0 Copay</td></tr>
</table>

	Preferred In-Network: IU Health, CVS, Kroger/Payless	Non-Preferred Out-of-Network:
Traditional PPO Medical Plan and HRA Member Cost per Prescription* **		
Tier 1 – Generic (preferred)	**30-day: $4 90-day: $10**	**30-day: $25; 90-day: N/A**
Tier 2 – Generic	**30-day: $10 90-day: $25**	**30-day: $25; 90-day: N/A**
Tier 3 – Brand (preferred); select generics	**30-day: $30 90-day: $75**	**30-day: $50; 90-day: N/A**
Tier 4 – Brand (non-preferred); generics (non-preferred)	**30-day: 30% coinsurance ($50 min, $100 max) 90- day: 30% coinsurance ($150 min, $300 max)**	**30-day: 50% coinsurance ($150 min, $300 max); 90-day: N/A**
Tier 5 – Specialty; Biotech medications (available only at IU Health Retail/Mail Pharmacies)	**30-day:25% coinsurance ($75 min, $250 max); 90-day: N/A**	**30-day: N/A 90-day: N/A**
Mail Order	**Yes; through IUH Mail Order, same Copays as above**	**N/A**
Preventive Medications	**Yes; $0 Copay**	**Yes; $0 Copay**

* Each covered prescription (unique, drug, dose form, and strength) will be subject to Copay or Coinsurance based on its day supply and the Plan design. Each prescription must meet all established Plan criteria including quantity, gender, and age limits, and any other utilization program that is in place such as Prior Authorization, step therapy, or split tablet.

** Preferred In-network pharmacies include: IU Health, CVS, Kroger/Payless. Participants may only fill 90-day and specialty medications at IU Health Retail and Mail Order Pharmacies.

Medical and Pharmacy Copay, Deductible, Coinsurance Accumulation Chart

	HSA Medical Plan	HSA Medical Saver Plan	PPO and HRA Medical Plan*
Copays apply to the Deductible	N/A – Covered Person/Family pays 100% until the Deductible is satisfied. Once the Deductible is satisfied, the member pays Coinsurance, rather than a flat Copay, which does apply toward the Deductible. *See next row*		N/A – Copays do not apply toward the Deductible
Coinsurance applies to the Deductible	✓	✓	N/A – Coinsurance does not apply toward the Deductible
Copays apply to the Out-of- Pocket Maximum	N/A – Covered Person/Family pays **100%** until the Deductible is satisfied. Once the Deductible is satisfied, the member pays Coinsurance, rather than a flat Copay, which does apply toward the out-of-pocket maximum. *See next row*		✓
Coinsurance applies to the Out-of-Pocket Maximum	✓	✓	✓
Deductible applies to the Out-of-Pocket Maximum	✓	✓	✓

Medical Management:

IU Health Plans is designed to administer health insurance benefits for Covered Persons. To ensure that provided services are Clinically Appropriate, Medically Necessary, and cost effective, IU Health Plans Medical Management Department provides Utilization Management and Case Management Services.

IU Health Plans Medical Management Department performs Utilization Review upon request, by Primary Care Physicians (PCPs), specialty care Physicians, Behavioral Health clinicians, and a wide variety of other health practitioners. The scope of these services includes, but is not limited to, the following:

1. Inpatient care
2. Outpatient/Ambulatory care
3. Surgical Services
4. Office-based procedures
5. Behavioral Health-Inpatient
6. Skilled Nursing Facilities, Hospice, rehabilitation and home health services
7. Home infusions and Durable Medical Equipment
8. Referrals to out-of-Network Providers
9. Care coordination

Urgent Review (which may be referred to as expedited) is a request for review of services, either before or during treatment, related to an Illness, disease, condition, Injury, or a disability, that with delay of review and subsequent determination, would seriously jeopardize the Covered Person's:

1. Life or health;
2. Ability to reach and maintain maximum function.
3. In the opinion of the treating Physician would subject the Covered Person to severe pain that cannot be adequately treated without the care and treatment that is the subject of the Appeal.
4.

Timeframe for Decision and Notification: 72 hours
(*This requires submission of the clinical documentation necessary to complete the review)

Pre-service, concurrent, and post service are the case request types fulfilled by IU Health Medical Management.

Pre-service review (which may be referred to as Prior Authorization) is a request for services placed prior to care delivery. This process helps to ensure, before services or care is delivered, that the care and setting are Clinically Appropriate.
Timeframe for Decision and Notification: 15 days

Concurrent review ensures that services provided during ongoing care continue to meet guidelines supporting appropriateness for that level of care. Concurrent review processes also include discharge planning, in which a Nurse Reviewer evaluates a plan of care, screens for discharge planning needs, and collaborates with providers and Inpatient Care Managers to ensure seamless transitions of care.
Timeframe for Decision and Notification: 72 hours

Post service review (which may be referred to as retro-review or authorization) is a request for review, when services have already been rendered. IU Health Plans completes post service reviews, but recommends all services be reviewed prior to the date(s) of service, where feasible**.**
Timeframe for Submission: 30 Calendar Days from Date of Service
Timeframe for Decision and Notification: 30 Days

All unscheduled admissions or service requests that appear to be outside the scope of a member's coverage, or that are non-compliant with delivery system or Utilization Management guidelines, are referred to a Physician Reviewer for determination of benefit coverage. Reimbursement for medical and Behavioral Health services is based on confirmed clinical appropriateness and medical necessity, through the review processes described above.

Case Management

Case Management is a collaborative process that assists members with coordination of care needs, allowing them to reach their optimum level of wellness and self-management. It is characterized by advocacy, communication, and resource management that promotes cost effective interventions and outcomes. Selection of members for Case Management services may include, but are not limited to, the following:

1. When coordination of multiple practitioners or multiple resources is required
2. Physician or self-referrals for coordination of care
3. When benefits are exhausted or when care may exceed the benefits available to the member
4. When utilization patterns demonstrate a need for improved self-management through education of and assistance, providing information for evidence based practice around management of chronic or avoidable diseases
5. Catastrophic Injury or Illness

Transition of Care Coverage

Transition of care coverage allows you to continue to receive treatment for Covered Services with a doctor and/or Facility that does not participate in an IU Health Plan's Network for a defined period of time until the safe transfer of care to an in-Network doctor and/or Facility can be arranged.

You may be eligible if you are:

1. A new enrollee in one of the Plan's Medical Plans and you apply for Transition of Care at the time of enrollment or no later than 30 days after the Effective Date of your coverage or

2. An existing enrollee whose doctor and/or Facility is leaving the IU Health Plans Network

Examples of medical conditions that may qualify for Transition of Care include, but are not limited to:

1. Pregnancy at the time of the Effective Date of coverage.
2. Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
3. Trauma.
4. Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
5. Recent major surgeries still in the follow-up period (generally 6 to 8 weeks).
6. Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions.
7. Hospital Confinement on the Plan effective date.
8. Behavioral Health conditions during active treatment.

The Transition of Care Request Form, including instructions for completion and submission for review, can be located at myiuhealthplans.com.

Referrals/Tier 1 Level Benefits

Referrals are not needed to see a Provider for Covered Services. It is the Covered Person's responsibility to ensure services are performed by Network Providers to receive the highest level Tier 1 payment for Covered Services. If there is no Tier 1 Network Provider within a 60 mile radius of where the Covered Person lives or works (or within a 30 mile radius if services sought are expected to be provided at least biweekly or more often) or if there is no appointment available with a Network Provider within 30 days then Tier 1 benefits may be granted by the Plan upon prior request to the Plan by the Covered Person. Continuity of care requests for a new Covered Person to use Non-Network Providers at a Tier 1 benefit level shall only be granted in the event the Covered Person completes the Transition of Care Form and meets Plan criteria and a high risk profile. The following list of services are routinely covered at Tier I, and do not require prospective review.

Non-Network anesthesiologist if the operating Facility is a Participating Provider.

1. Radiologist or pathologist services for interpretation of x-rays and laboratory tests provided by a Non-Network Provider when the Facility participates in the Network.

2. While confined to a Network Hospital, the Network Physician requests a consultation from the Non-Network Provider.

3. Medically Necessary services, supplies and treatments not available through any Network Provider.

4. Ambulance services.

5. Non-Network assistant surgeon charges if the operating surgeon is a Network Provider.

6. Urgent Care treatment.

7. Emergency treatment at a Network Facility by a Non-Network Provider. If the Covered Person is admitted to the Hospital after such Emergency treatment, Covered Services shall be payable at the Network Provider level.

Coverage Clarifications

The following section provides benefit coverage clarifications, further explaining the previous Summary of Benefits chart. Behavioral Health includes all services for Mental Health and Chemical Dependency. Refer to Section Seven: Definition of Terms for additional information about how services are defined. Refer to the Summary of Benefits for coverage levels.

Note: When IU Health Facilities are utilized for Covered Services, the Covered Person's Coinsurance and Out-of-Pocket Maximum is lower. See the Summary of Benefits for Coinsurance percentages.

When a Covered Person receives services, the Deductible is subtracted from the Covered Charge and the benefits will then be calculated from the remaining amount, based on the applicable Copayment, Coinsurance, maximums and benefits limits. Copays are paid at time of service.

Allergy

The Plan pays for allergy testing that consists of percutaneous, intracutaneus and patch tests, and allergy injections.

Allergy testing is subject to the Specialty office visit Copayment or the Deductible and Coinsurance depending on the Covered Person's medical Plan and choice of where care is received.

Injections are covered at 100% on Traditional PPO Plan, injections are subject to Deductible and Coinsurance on the HSA Medical Plan, HSA Medical Saver Plan and HRA Medical Plan .

Serum is subject to the Deductible and Coinsurance.

Ambulance Services

Ambulance services must be provided by a licensed air or ground ambulance which is staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals and equipped to transport the sick or injured.

Covered Services shall include:

1. Ambulance service for air or ground transportation for the Covered Person from the place of Injury or serious medical incident to the nearest Hospital where treatment can be given.
2. Non-emergent ambulance service is covered only to transport the Covered Person to or from a Hospital or between Hospitals or Extended Care Facilities for required treatment. Non-emergent ambulance transport must receive Prior Authorization from Medical Management. Service will be covered if ambulance transport is determined to be Medically Necessary by Medical Management. Such transportation is covered only from the initial Hospital to the nearest Hospital qualified to render the special treatment. Ambulance service between Hospitals is also covered if the Covered Person is required by the Plan Administrator to move from a Non-Network Provider to a Network Provider.
3. Ambulance service when a Covered Person is ordered by an Employer, school, fire or public safety official to be transported by ambulance and the Covered Person is not in a position to refuse.

Ambulance services are not Covered Services if they are:

1. To a Physician's office or clinic;
2. To a morgue or funeral home.
3. An Ambulance service which is only for the convenience of the Covered Person, family or Physician or is not Medically Necessary.

Autism

Autism Spectrum Disorder (ASD) and Pervasive Developmental Delay (PDD) coverage will be in parity and consistent with coverage for other medical and psychological conditions, such as for visit limits.

Services and treatments must be "established" treatments as defined by the National Standards Project. Established treatments will be covered benefits and are defined by the National Standards Project as treatments for which scientific evidence has shown the intervention produces beneficial effects, although universal improvements cannot be expected to occur in all individuals.

ABA Therapy for Autism – Applied Behavior Analysis therapy requires Precertification and involves the modification of situational events that typically precede the occurrence of a target behavior. These alterations are made to increase the likelihood of success or reduce the likelihood of problems occurring.

Treatment includes but is not restricted to: behavior chain interruption (for increasing behaviors); behavioral momentum; choice; contriving motivational operations; cueing and prompting/prompt fading procedures; environmental enrichment; environmental modification of task demands, social comments, adult presence, intertribal interval, seating, familiarity with stimuli; errorless learning; errorless compliance; habit reversal; incorporating echolalia, special interests, thematic activities, or ritualistic/obsessional activities into tasks; maintenance interspersal; noncontingent reinforcement; priming; stimulus variation; and time delay.

ABA therapy performed in the home or in an Outpatient setting is subject to the Deductible and Coinsurance.

Behavioral/ Mental Health and Chemical Dependency

Inpatient or Partial Confinement is subject to Precertification. The Plan covers services, supplies and treatment during Confinement or Partial Confinement in a Hospital or Treatment Center related to the treatment of Behavioral/Mental Health and Chemical Dependency. Coverage for Inpatient and Outpatient treatment of Behavioral/Mental Health and Chemical Dependency conditions are provided to the same extent and degree as for the treatment of a physical Illness.

Outpatient visits are Covered Services for short-term evaluation or crisis intervention Behavioral/Mental Health and Chemical Dependency. Physician services for Outpatient visits are paid the same as the medical office visit. Prior Authorization for services is not required.

Chiropractic Care

Covered Services include an initial or follow up consultation and spinal manipulation, subject to the Schedule of Benefits. Manipulation whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward the Benefits for Chiropractic Care.

Coinsurance

The Plan pays a specified percentage for Covered Services at the Customary and Reasonable Amount for Non-Network Providers, or the percentage of the Negotiated Rate for Network Providers as specified in the Schedule of Benefits in this section.

The Covered Person is responsible for the difference between the percentage the Plan paid and 100 percent of the Negotiated Rate for Network Providers. For Non-Network Providers, the Covered Person is responsible for the difference between the percentage the Plan pays of the Customary and Reasonable Amount and 100 percent of the billed amount.

Contraceptives

The charges for all FDA approved contraceptive methods, except oral contraceptives, in accordance with Health Resources and Services Administration (HRSA) guidelines, subject to regional medical management. Note: Oral contraceptives are covered under the Prescription Drug Benefit section.

Copayments

The Copayment is the amount the Covered Person is expected to pay for certain services, supplies or treatment at the time of service. Copayments are not applied to the calendar year Deductibles.

Cosmetic Surgery

Specified Cosmetic/reconstructive Surgeries are subject to Precertification. Cosmetic Surgery shall be a Covered Expense provided:

1. A Covered Person receives an Injury as a result of an accident and as a result requires Surgery. Cosmetic Surgery and treatment must be for the purpose of restoring the Covered Person to his or her normal function immediately prior to the accident.
2. It is required to correct a congenital anomaly, for example, a birth defect for a child.

Mastectomy

Covered Services shall include the following:

- Medically Necessary mastectomy, including complications from a mastectomy, including lymphedemas.
- Reconstructive breast Surgery necessary because of a mastectomy.
- Reconstructive breast Surgery on the non-diseased breast to make it equal in size with the diseased breast following reconstructive Surgery on the diseased breast.
- External breast prosthesis and permanent internal breast prosthesis.

Deductibles

Individual Deductible
The individual Deductible is the specified dollar amount of Covered Charges a Covered Person must have Incurred during the calendar year before the Plan pays applicable benefits and the individual will be considered to have met the Deductible for the remainder of the calendar year. The individual Deductible amount is shown on the Schedule of Benefits. Benefits are paid according to the date the claim is received by the Plan, not the service date.

Individual Deductible applies to coverage for one person. In the case of Employee Only coverage, the Employee must satisfy the Deductible before Coinsurance and contributions to the Out-of-Pocket Maximum begin.

Family Deductible
The family Deductible means the specified dollar amount of Covered Charges that must be Incurred by family Covered Persons before the Plan pays applicable benefits and family Covered Persons will be considered to have met the Deductible for the remainder of the calendar year. The family Deductible amount is shown on the Schedule of Benefits. Benefits are paid according to the date the claim is received by the Plan, not the service date.

In each calendar year, if Covered Persons of a family incur Covered Charges that are subject to the Deductible, equal to or greater than the dollar amount of the family Deductible shown on the Schedule of Benefits, the family Deductible will be considered satisfied for all family Covered Persons for that calendar year. Any number of family Covered Persons' Covered Services may contribute to satisfying the family Deductible amount.

Dental Services

Covered Services shall include the initial repair of the jaw, sound natural teeth, mouth or face provided it is the result of an Injury. Treatment must be provided within 12 months after the Injury or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental-related Injury, there may be several years between the accident and the final repair. Damage to the teeth as a result of chewing or biting shall not be considered an Injury under this benefit. Covered Services for accidental dental work include, but are not limited to:

1. Oral examinations;
2. X-rays;
3. Tests and laboratory examinations;
4. Restorations;
5. Prosthetic services;
6. Oral Surgery;
7. Mandibular/maxillary reconstruction;
8. Anesthesia.

Diagnostic Services and Supplies

Covered Services shall include, but are not limited to, the following:

1. X-ray and other radiology services, including mammograms for any Covered Person diagnosed with breast disease; Coverage for radiology services requires Precertification for anything on the Prior Authorization list. The list of services requiring Precertification can change at any time.
2. Laboratory and pathology services;
3. Cardiographic, encephalographic, and radioisotope tests;
4. Ultrasound services;
5. Allergy tests;

6. Electrocardiograms (EKG);
7. Electromyograms (EMG) (surface EMGs are not covered);
8. Echocardiograms;
9. Bone density studies;
10. Advanced Imaging:
    a. CAT Scans (CT),
    b. Positron Emission Tomography (PET Scans),
    c. Single Photon Emission Computed Tomography (SPECT Scans)
    d. Magnetic Resonance Angiography (MRA),
    e. Computed Tomography Angiography (CTA),
    f. Magnetic Resonance Imaging (MRI).

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether the test is performed in a Hospital or Physician's office.

Coverage for some radiology services requires Precertification. The list of services requiring Precertification can be found at myiuhealthplans.com and is subject to change at any time.

Exclusions – Unless otherwise provided, services not covered include:

1. Audiometric testing (when performed to determine the need for a hearing aid)
2. Eye refractions
3. Examinations for the fitting of eyeglasses, contact lenses or hearing aids
4. Dental examinations
5. Premarital examinations
6. Research studies, screening examinations, Physician examinations or check-ups other than those described under well-child care and well-person care.

Durable Medical Equipment

Rental or purchase, whichever is less costly, of necessary Durable Medical Equipment, which is prescribed by a Physician and required for therapeutic use by the Covered Person, shall be a Covered Service. Equipment ordered prior to the Covered Person's Effective Date of coverage is not covered, even if delivered after the Effective Date of coverage. Repair or replacement of purchased Durable Medical Equipment, which is Medically Necessary due to normal use or physiological change in the patient's condition, will be considered a Covered Service. Coverage for Durable Medical Equipment requires Precertification for any services on the Prior Authorization list and all services over $500. The list of services requiring Precertification can change at any time.

Equipment containing features of an anesthetic nature or features of a medical nature which are not required by the Covered Person's condition, or where there exists a reasonably feasible and Clinically Appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the customary and reasonable charge for the equipment which meets the Covered Person's medical needs.

Covered Service includes: the rental, initial purchase, repair and replacement of equipment that is appropriate for home use and is used to treat Illness or Injury.

Exclusions include: Routine maintenance. Covered Charges for deluxe items are limited to the cost of standard items. Covered Charges for rental are limited to the purchase price of the equipment.

Prostheses

Covered Services include initial purchase, fitting, needed adjustment, repair and replacement of fitted prosthetic devices (artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes) and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues, or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetics require Prior Authorization for any services over $500. Covered Services shall include, but are not limited to:

1. Aids and supports for defective parts of the body, including but not limited to internal heart valves, internal pacemakers, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates and vitallium heads for joint reconstruction;
2. Left Ventricular Artificial Devices (LVAD) – when used as a bridge to a heart transplant or as a life saving/prolonging treatment;
3. Breast prosthesis, whether internal or external, following a mastectomy and two surgical bras per calendar year;
4. Minor devices for repair such as screws, nails, sutures and wire mesh;
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses following lens implantation are also covered. If cataract Surgery is performed, lenses are usually inserted during the same operative session;
7. Artificial gut systems (parental devices necessary for long-term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered);
8. Cochlear implants;
9. Electronic speech aids in post laryngectomy or permanently inoperative situations;
10. "Space shoes" when used as a substitute device when all or a substantial portion of the forefoot is absent;
11. Wigs (the first one following cancer treatment, one per calendar year not to exceed a maximum of $500).

No benefits are payable under this provision of the Plan for: dentures replacing teeth or structures directly supporting teeth; dental appliances; non-rigid appliances such as elastic

stockings, garter belts, arch supports and corsets; hairpieces for male pattern baldness (alopecia); wigs, except as specified.

Orthotics
Covered Services include the initial purchase, fitting and repair and replacement of a custom-made orthotic device or appliance (a rigid or semi-rigid supportive device used to support, align, prevent or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part). The cost of casting, molding, fittings and adjustments are also included. Orthotics require Prior Authorization for services more than $500. Covered orthotic devices include, but are not limited to:

1. Cervical collars;
2. Ankle foot orthotics;
3. Corsets (back and special surgical);
4. Splints (extremities);
5. Trusses and supports;
6. Slings;
7. Wristlets;
8. Built-up shoe;
9. Custom-made shoe inserts.

Medically Necessary replacement of orthotic devices or appliance will be covered, but limited to once per calendar year. However, additional replacements will be covered for Covered Persons under age 18 if required due to rapid growth or for any Covered Person when the orthotic is damaged or cannot be repaired.

No benefits are payable under this provision of the Plan for: orthopedic shoes; foot support devices, such as arch supports or corrective shoes, unless they are an integral part of a leg brace; standard elastic stockings, garter belts and other supplies not specially made and fitted.

Emergency Services/Emergency Room

A life-threatening Emergency is a condition or symptom that arises suddenly and unexpectedly. It has acute symptoms of such severity that without immediate medical attention it could be reasonably expected by a prudent layperson (person with an average knowledge of health and medicine) to:

- Permanently jeopardize the individual's health;
- Result in serious medical consequences;
- Cause serious impairment of bodily function; or
- Result in serious harm or permanent dysfunction of any bodily organ or part.

If a life-threatening Emergency occurs, call 911 or seek Medical Care immediately. Remember to advise your primary Physician for coordination of follow up care. Emergency Copayments apply for Traditional Plan members unless admitted.

See Urgent Care for information about receiving services in an Urgent Care situation or at a CVS MinuteClinic.

Extended Care/Skilled Nursing

Coverage for an Extended Care Facility or skilled nursing stay is subject to Precertification. Custodial Care is not covered. Covered Charges shall include:

1. Room and Board (including regular daily services, supplies and treatments furnished by the Extended Care Facility) limited to the Facility's average semiprivate room rate; and
2. Other services, supplies and treatment ordered by a Physician and furnished by the Extended Care Facility for Inpatient Medical Care.

Foreign Travel

See Urgent Care and Emergency care.

Gender Reassignment

Gender reassignment surgery is covered and is subject to Precertification. Services are limited to once per lifetime.

Exclusions include:

1. Transitioning back to natal gender following gender reassignment surgery;
2. Revisions following gender reassignment surgery except for life-threatening complications or complications which prevent normal physiologic function; and
3. Cosmetic services

Home HealthCare

Home Healthcare is subject to Precertification. Home Healthcare enables the Covered Person to receive treatment in his home for an Illness or Injury instead of being confined in a Hospital or Extended Care Facility. Services must be provided on a Part-Time visiting basis according to a Plan of treatment. The Covered Person must have been referred to a Home Healthcare Agency by a Physician, and the Provider must not be a Covered Person of your immediate family.

Covered Services shall include, but are not limited to:

1. Intermittent skilled nursing care by a registered Nurse or Licensed Practical Nurse;
2. Diagnostic services;
3. Medical/social services;
4. Nutritional guidance;
5. Home Health Aide Services;
6. Therapy services;

7. Medical/surgical supplies;
8. Durable Medical Equipment;
9. Prescription Drugs if provided and billed by a Home Healthcare Agency;
10. Private duty nursing services.

Health Promotion Programs – Healthy Results

Call 317.963.WELL to schedule a biometric screening, and speak with a health coach or simply to learn more about Healthy Results. For up to date information, logon to: myiuhealthplans.com.

Home Infusion Therapy

Covered Services will include charges for home infusion therapy, including a combination of nursing, Durable Medical Equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy.

Hospice Care

Hospice care is subject to Precertification. Hospice care is a healthcare program that provides a coordinated set of services at home, in Outpatient settings, or in Facility settings for a Covered Person suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the Covered Person's attending Physician certifies that:

1. The Covered Person is terminally ill, and
2. The Covered Person has a life expectancy of six months or less.

Covered Services shall include:

1. Skilled nursing services by a registered Nurse or licensed practical Nurse;
2. Diagnostic services;
3. Physical, speech and inhalations therapies;
4. Medical supplies, equipment and appliances;
5. Counseling services (except bereavement counseling);
6. Inpatient stay at a Hospice;
7. Prescription Drugs obtained from the Hospice.

Charges Incurred during periods of remission are not eligible under this provision. Any Covered Charges paid under Hospice benefits will not be considered a Covered Charge under any other provision of this Plan.

Hospital/Ambulatory Surgical Facility – Inpatient & Outpatient

Inpatient Hospital admissions and specified Outpatient procedures and services are subject to obtaining Precertification from the IU Health Plans Medical Management Department. Obtaining Precertification is the responsibility of both the Physician and the Plan Covered Person. (Refer to the section on Medical Management for additional Precertification information.) If a patient is transferred from one Hospital to another on the same day, the Copay for the second admission is waived. Refer to the Schedule of Benefits for benefits coverage.

Covered Services shall include:

1. Room and Board for treatment in a Hospital, including intensive care units, cardiac care units and similar necessary accommodations. Covered Services for Room and Board shall be limited to the Hospital's Semi-Private rate. Covered Services for intensive care or cardiac care units shall be the Customary and Reasonable Amount or Negotiated Rate, as applicable. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the Covered Person.
2. Miscellaneous Hospital services, supplies, and treatments including, but not limited to:
    a. Admission fees, and other fees assessed by the Hospital for rendering Medically Necessary services, supplies, and treatments;
    b. Use of operating, treatment or delivery rooms;
    c. Anesthesia, anesthesia supplies and its administration by an employee of the Hospital;
    d. Medical and surgical dressings and supplies, casts and splints;
    e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
    f. Drugs and medicines (except drugs not used or consumed in the Hospital);
    g. X-ray and diagnostic laboratory procedures and services;
    h. Oxygen and other gas therapy and the administration thereof;
    i. Therapy services.
3. Services, supplies, and treatments described above furnished in an Outpatient setting by an Ambulatory Surgical Facility, including lithotripsy treatment.
4. Charges for preadmission testing (x-rays and lab tests) performed within seven days prior to a Hospital admission which are related to the condition which is necessitating the Hospital stay. Such tests shall be payable even if they result in additional medical treatment prior to admission or if they show that the Hospital stay is not necessary. Such tests shall not be payable if the same tests are performed again after the Covered Person has been admitted.

Infertility

Infertility is a Covered Service up to the diagnosis of the medical condition.

Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT) are not covered.

Maximum Benefit

The Schedule of Benefits contains Maximum Benefit limitations for specified conditions, including, but not limited to: physical, occupational, and speech therapy, and Chiropractic Care.

Medical Services

Covered Services are subject to applicable Plan provisions, including, but not limited to: Deductible, Copayment, Coinsurance, Maximum Benefit and limitations. Services, supplies and treatment must not exceed the Customary and Reasonable Amount or Negotiated Rate and must be ordered by a Physician or Provider, and be Medically Necessary for the care of a Covered Person.

Morbid Obesity Treatment

Surgical treatment requires Precertification. Covered Services shall include charges for surgical treatment of Morbid Obesity for Covered Persons with health problems, which are aggravated by or related to the Morbid Obesity, including, but not limited to gastric bypass, gastric stapling or gastric balloon.

Covered Services shall include Physician office visits, dietician consults and Behavioral Health counseling in conjunction with a Physician supervised weight loss program.

Out-of-Pocket Maximum Per Calendar Year

After the individual or family has Incurred an amount equal to the Out-of-Pocket Maximum listed on the Summary of Benefits (after satisfaction of applicable Deductibles), the Plan will begin to pay 100 percent for Covered Services for the remainder of the calendar year or until the Maximum Benefit has been reached (where applicable).

Out-of-Pocket Maximum – The following items do not apply toward satisfying the calendar year Out-of-Pocket Maximum:

1. Expenses for services, supplies and treatments not covered by this Plan, to include charges in excess of the Customary and Reasonable Amount or Negotiated Rate, as applicable.
2. Dental services are not covered; dental services are only available under separately selected dental options.
3. Expense Incurred as a result of failure to obtain Precertification.

Physician Services

Physician Covered Services shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, Inpatient visits, and home visits.
2. Surgical treatment. Separate payment will not be made for Inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   For related operations or procedures performed through the same incision or in the same operative field, covered expenses shall include the surgical allowance for the highest paying procedure, plus 50 percent of the surgical allowance for second highest paying procedure and 25 percent of the surgical allowance for each additional procedure.

   When two or more unrelated operations or procedures are performed at the same operative session, Covered Charges shall include the surgical allowance for each procedure.
3. Surgical assistance provided by a Physician if it is determined that the condition of the Covered Person or the type of surgical procedure requires such assistance. Covered Charges for the services of an assistant surgeon shall be limited to 20 percent of the surgeon's billed charges or the contracted amount whichever is less.
4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.
5. Consultations requested by the attending Physician during a Hospital stay. Consultations do not include staff consultations, which are required by a Hospital's rules and regulations.
6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.
8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

Inpatient Medical Visits, Consultations
One visit per Physician per day per diagnosis is allowed, unless a surgeon's visits are included with the Surgery fee and are covered under the Plan.

Assistant Surgeon
A Covered Service if the surgeon needs the assistance of a second surgeon during major Surgery. Includes surgical assistance provided by a Physician if it is determined that the condition of the Covered Person or the type of surgical procedure requires such assistance. Covered Charges for the services of an assistant surgeon shall be limited to 20 percent of the surgeon's allowable amount.

Anesthesia
General and local anesthesia (other than local infiltration anesthesia and anesthesia supplies) when it is Medically Necessary. The service must be performed by a Provider other than the surgeon or assistant surgeon.

Second Surgical Opinion
Benefits for a second surgical opinion will be payable if an elective surgical procedure (non-Emergency Surgery) is recommended by the Physician. The Physician providing the second opinion regarding the Medical Necessity of such Surgery must be a board-certified Specialist in the treatment of the Covered Person's Illness or Injury and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The Plan will consider payment for a third opinion the same as a second surgical opinion.

Podiatry Services

Covered Services include the treatment of fractures and dislocations of bones of the foot and surgical treatments (incision and drainage, removal of lesions, removal of infected toenails or nail roots). Covered Services for nonsurgical care includes: metabolic (diabetics) or peripheral-vascular Illness. The nonsurgical care for Covered Persons with diabetes, peripheral neuropathy or peripheral vascular disease includes nonsurgical care of the toenails, treatment of corns and calluses and foot injections.

Pregnancy

Covered Services for pregnancy or Complications of Pregnancy shall be provided for a Covered Person, a covered spouse of a covered Employee, or Dependent children.

Pregnant and postpartum individuals will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment and supplies.

100 percent coverage is provided for breast pumps and supplies obtained through IU Health Homecare Expressions. Rentals are not covered. Precertification is required for Hospital grade breast pumps.

For further details contact IU Health Plans Member Services at 800.873.2022 or 317.816.5170 or visit the IU Health Plans website: myiuhealthplans.com.

In the event of early discharge from a Hospital or Birthing Center following delivery, the Plan will cover at-home post-delivery care visits at the parent's home by a Physician or Nurse when performed no later than 48 hours following discharge from the Hospital. Covered Services include, but are not limited to:

1. Parent education;
2. Physical assessment;
3. Assessment of the home support system;

4. Assistance and training in breast or bottle feeding;
5. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

   At the patient's discretion, this visit may occur at a Physician's office.

Note: You or your Physician must call the Plan within one working day after your maternity admission. Additional days must be certified/authorized if a newborn remains in the Hospital after the mother's discharge. See the Medical Management section for more information about authorizing/certifying Inpatient admissions.

Note: You must add your newborn to your coverage within 31 days of birth to be enrolled in the Plan. If this is not accomplished within the first 31 days, the newborn will not be able to be added until the next annual open enrollment period. Payment of claims within the first 31 days does not mean your newborn has been added. Please contact Human Resources to obtain enrollment information.

Nurse midwives are considered Network Providers. Refer to the Provider Directory to ensure they are Participating in the Network.

The Plan shall cover services, supplies and treatments for elective and Medically Necessary abortions and complications from an abortion.

Birthing Center
Covered Services shall include services, supplies and treatments provided at a Birthing Center when the Physician in charge is acting within the scope of his/her license and the Birthing Center meets all legal requirements. Services of a Network midwife acting within the scope of the license or registration are Covered Services provided that the state in which such service is performed has legally recognized midwife delivery.

Newborns' and Mothers' Health Protection Act

Under the Newborns' Act, the health plan may not restrict benefits for a hospital stay in connection with childbirth to less than 48-hours (96-hours in case of a cesarean section), unless the attending provider (in consultation with the mother) decides to discharge earlier. Plans may not require providers to obtain authorization from the plan for prescribing the stay. In addition, plans may not deny a stay within the 48-hour (or 96-hour) period because the Plan's utilization reviewer does not think such a stay is medically necessary. The plan must eliminate this preauthorization requirement with respect to hospital stays in connection with childbirth for the first 48-hours (or 96-hours in the case of a cesarean section). The Plan may impose such an authorization requirement for hospital stays beyond this period. In addition, the Plan may impose a requirement on the mother to give notice of a pregnancy in order to obtain a certain level of cost-sharing or to use certain medical facilities. However, the type of preauthorization required by this Plan (within 48- or 96-hour period and based on medical necessity) must be eliminated.

Prescription Drug Benefit

The Plan Prescription Drug benefit utilizes a five-tier drug formulary. A drug formulary is a listing of the Plan covered medications. Each formulary medication is assigned to one of the five tiers, and each tier has a Copay or Coinsurance assigned to it. This leads to appropriate and cost-effective use of pharmaceutical therapies grounded in evidence-based clinical guidelines and can be the key to a successful strategy for improving individual patient outcomes and containing overall healthcare costs.

In this section you will find helpful information about:

- Customer Solutions;
- Network Pharmacies;
- Prescription Drug Benefit;
- Covered Prescription Drugs;
- Prescription Benefit Exclusions;
- Utilization Programs;
- Emergency Medications;
- Prescription Drug Coverage Under Medicare

Customer Solutions

If you have any questions about your pharmacy benefits, contact the pharmacy benefits administrator at 844.432.0704 (available 24 hours a day, 365 days a year).

Network Pharmacies

Through the Prescription Drug Benefit, there are three options for filling prescriptions:

a) Preferred In-Network pharmacies IU Health Retail, CVS, Kroger/Payless
b) Preferred In-Network IU Health mail order pharmacy,
   317.963.7100 or 844.678.7100; Fax: 317.963.7119
   355 W 16th St. Suite 1600 GH 1074, Indianapolis, IN 46202
c) Non-Preferred In-Network retail pharmacies

Covered Persons with the Plan receive enhanced prescription coverage when utilizing IU Health Retail pharmacies, many of which have Saturday hours in addition to extended Monday-Friday hours.

A larger retail Network of Preferred In-Network Pharmacies is also available to Covered Persons through Kroger and CVS retail pharmacies. Medications can be filled up to 30-days supply at these locations (specialty excluded).

The largest retail Network is the Non-preferred In-Network pharmacies and includes the majority of retail pharmacy chains; however, the cost of receiving prescriptions from these retail locations is higher than through the Preferred pharmacies. Medications can be filled up to 30-days supply at these locations (specialty excluded).

A listing of the Network Pharmacies is available on the Plan website: myiuhealthplans.com.

Present your Plan ID Card at the pharmacy when you have your prescription filled or to obtain a refill. Please note: The pharmacist may ask for the Covered Person's birth date as a check for safety and quality care.

2017 Pharmacy Network

2017 Pharmacy Network Please see a complete list of In-Network pharmacies on the IU Health Plans website at: myiuhealthplans.com	
Preferred In-Network	Non-Preferred Network
IU Health retail, CVS and Kroger/Payless IU Health mail order	All other retail chains in PBM national network

Prescription Drug Benefit

Please refer to the IU Health Pharmacy Benefits information in the Summary of Benefits.

90 day supplies and specialty medications are available through IU Health Retail Pharmacies and IU Health Mail Order Pharmacy only.

1. Drugs that are on the formulary (listing of covered drugs) and prescribed by a Physician that require a prescription either by federal or state law, except drugs excluded by the Plan and those not meeting established criteria for coverage (i.e. Quantity, age, gender, limits, Prior Authorization criteria, or other established criteria). *For a complete listing of formulary medications, please refer to myiuhealthplans.com .*
    a. Formulary insulin, insulin syringes, and needles via a legal prescription.
    b. Formulary diabetic testing supplies via a legal prescription.

The benefit applies only when a Covered Person incurs a covered Prescription Drug charge for a formulary medication, meets formulary coverage requirements (i.e. Prior Authorization, step therapy, in addition to quantity, gender , and age limits, etc), and presents a legal prescription to a Network pharmacy.

Prescription Drug Exclusions

The following are not covered under the Outpatient Prescription Drug Rider. Certain Services excluded below may be covered under other benefits of your group. Please refer to the applicable benefit to determine if drugs are covered. Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:

1. Any drug prescribed for intended use other than for:
    - Indications approved by the FDA
    - Off-label indications recognized through peer-reviewed medical literature
2. Any drug prescribed for a sickness or bodily injury not covered under this Plan
3. Drugs that have an active ingredient where at least one drug that contains that active ingredient is covered on the formulary
4. Any drug, medicine, or medication that is either:

- Labeled, “Caution -- limited by federal law to investigational use”
- Experimental or investigational or for research purposes

5. Allergen extracts
6. Therapeutic devices or appliances, including, but not limited to:
   - Hypodermic needles and syringes (except needs and syringes for use with insulin and self-administered injectable drugs, whose coverage is approved by us)
   - Support garments
   - Test reagents
   - Mechanical pumps for delivery of medications
   - Other non-medical substances
7. Dietary supplements, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease
8. Nutritional products
9. Minerals
10. Growth hormones for idiopathic short stature
11. Growth hormones, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by us
12. Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride
13. Anabolic steroids, except for use in AIDS Wasting Syndrome or testosterone for laboratory confirmed diagnosis of low testosterone
14. Anorectic or any drug used for the purpose of weight control
15. Any drug used for cosmetic purposes, including, but not limited dermatologicals or stimulants for hair growth, and pigmenting or de-pigmenting agents
16. Any drug or medicine (unless duly noted on the drug list, preferred drug list or formulary) that is:
    - Lawfully obtainable without a prescription (over-the-counter drugs), except insulin
    - Available in prescription strength without a prescription
17. Drugs used to induce abortions
18. Infertility services including medications
19. Any drug prescribed for impotence and/or sexual dysfunction
20. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner
21. The administration of covered medication(s)
22. Prescriptions that are to be taken or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
    - Hospital
    - Skilled nursing facility
    - Hospice facility
23. Injectable drugs, including, but not limited to:
    - Immunizing agents, unless otherwise determined by us.
    - Biological sera
    - Blood
    - Blood plasma

- Unapproved self-administrated injectable drugs or specialty drugs

24. Prescription refills that exceed the drug-specific refill limit, the number specified by the healthcare practitioner, or the number allowed by law
25. Prescription refills dispensed more than a year from the date of the original order
26. Any portion of a prescription or refill that exceeds a 90-day supply when received from a mail order pharmacy or a retail pharmacy that participates in our program
27. Any portion of a prescription or refill that exceeds a 30-day supply when received from a retail pharmacy that does not participate in our program, which allows you to receive a 90-day supply of a prescription or refill
28. Any portion of a specialty drug of self-administered injectable drug that exceeds a 30-day supply, unless otherwise determined by us
29. Any portion of a prescription or refill that exceeds drug-specific QLL, is dispensed to a covered person whose age is outside the drug-specific age limits defined by us, and/or exceeds the QDL
30. Any drug for which step therapy or prior authorization is required, as determined by the Plan, and not obtained
31. Any drug that typically does not have a customary charge
32. Any drug, medicine, or medication received by you before you became covered under the Plan, or after the date your coverage under this Plan has ended
33. Any costs related to the mailing, sending or delivery of prescription drugs
34. Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than you
35. Any prescription or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged
36. Any drug, medicine, or supply to eliminate or reduce a dependency on, or addiction to, tobacco and tobacco products, unless coverage is mandated per the Affordable Care Act
37. Drug delivery implants
38. Drugs in the proton pump inhibitor and H2-receptor antagonist therapeutic category {i.e. omeprazole (Prilosec), pantoprazole (Protonix), lansoprazole (Prevacid), esomeprazole (Nexium), rabeprazole (Aciphex), dexlansoprazole (Dexilant), cimetidine (Tagamet), famotidine (Pepcid), nizatidine (Axid), and ranitidine (Zantac)}
39. Drugs in the intranasal steroid therapeutic category {i.e. fluticasone (Flonase, Veramyst), triamcinolone (Nasacort AQ), flunisolide (Nasarel), budesonide (Rhinocort), mometasone (Nasonex), beclomethasone (Beconase, QNASL), ciclesonide (Zetonna, Omnaris)}
40. Drugs in the hyaluronic acid therapeutic category (i.e. Orthovisc, Euflexxa, Synvisc, Supartz, Hyalgan, Gel-One)
41. Treatment for onychomycosis (nail fungus)
42. More than one prescription or refill for the same drug or equivalent medication prescribed until you have used, or should have used, at least 75 percent of the previous prescription or refill if the drug or therapeutic equivalent medication is purchased through a mail order or a retail pharmacy that participates in our program, and that pharmacy allows you to receive a 90-day supply of a prescription or refill, you must have used, or should have used at least 75 percent of the previous prescription (according to the prescribed dosage schedule)

43. Any amount you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription

These limitations and exclusions apply even if a healthcare practitioner has performed or prescribed a medically appropriate procedure, service, supply, or prescription. This does not prevent your healthcare practitioner or pharmacist from providing or performing the procedure, service, treatment, supply, or prescription. However the procedure, service, treatment, supply, or prescription will not be covered.

Utilization Programs

2017 Pharmacy Benefit Programs: IU Health (See location specific documents for Morgan, Tipton, White Memorial, Paoli, and SIP)						
Program	Description	Plan			Pharmacy Network	
		PPO Plan	HSA Plans	HRA Plans	Preferred In-Network: IU Health, Kroger, CVS	Non-Preferred Network
Copay Coinsurance	The amount that the member pays per prescription based on its day supply and the plan design the member is enrolled in. Each covered prescription (unique, drug, dose form, and strength) will be subject to a copay or coinsurance. Each prescription must meet all established plan criteria including quantity, gender, and age limits, and any other utilization program that is in place such as prior authorization, step therapy, or split tablet.	✓	✓	✓	✓	✓
Mail Order	Mail order is available through the IU Health Mail Order pharmacy for the same copay/coins as in-network pharmacies.	✓	✓	✓	✓	N/A
90 day supplies	Once established on a long-term maintenance medication, prescriptions may be filled for up to 90 days at a time at IU Health Retail and Mail Order pharmacies.	✓	✓	✓	IU Health Pharmacies Only	N/A
Specialty Medications	Medications requiring unique monitoring and/or use may be filled for up to a 30 day supply at IU Health Retail and Mail Order pharmacies.	✓	✓	✓	IU Health Pharmacies Only	N/A

2017 Pharmacy Benefit Programs: IU Health
(See location specific documents for Morgan, Tipton, White Memorial, Paoli, and SIP)

Program	Description	Plan			Pharmacy Network	
		PPO Plan	HSA Plans	HRA Plans	Preferred In-Network: IU Health, Kroger, CVS	Non-Preferred Network
$0 Preventive Medications	Members can fill prescriptions on the government mandated preventive medication list for $0.	✓	✓	✓	✓	✓
$0 Diabetic Testing Supplies	Members can fill covered diabetic supplies (including meters, test strips, lancets, control solution, insulin syringes, insulin needles, pen needles, alcohol swabs, and ketone strips) for $0.* Available to HSA-based medical plan members once deductible is fully met.	✓	✓	✓	✓	✓
Diabetic Supplies Bayer and One Touch Program	Preferred diabetic meters, test strips, and lancets are Bayer and One Touch brands: Bayer Contour®, Bayer Breeze 2®, One Touch Ultra®, One Touch Ultra Mini®, and One Touch Verio IQ®. All other brands will require documentation of medical necessity for coverage. *Available to HSA-based medical plan members once deductible is fully met.	✓	✓	✓	✓	✓
$0 Diabetic Medications	Based on income, certain members are able to receive many diabetic medications at $0 when filled at IU Health, CVS, and Kroger pharmacies.	✓	N/A	✓	✓	Medications available for OON copay/ coins
Mandatory Generic	If a brand medication is dispensed when a generic is available, the member pays the brand copay/coins in addition to the difference in cost between the brand and generic. Please note the additional copayment/coinsurance or penalty amount may exceed any previously stated maximum copayment, deductible, or maximum-out-of-pocket (MOOP) amount.	✓	✓	✓	✓	✓
Step Therapy	This program provides coverage for certain medications after members have met the requirements of having tried similar, previous therapies within the same medication class.	✓	✓	✓	✓	✓
Prior Authorization	Certain prescription medications have prior authorization requirements in place to ensure appropriate utilization prior to filling the prescription.	✓	✓	✓	✓	✓
Quantity, Gender, Age Limits	Limits that are on certain medications to promote appropriate prescribing and/or preferred alternatives.	✓	✓	✓	✓	✓

2017 Pharmacy Benefit Programs: IU Health (See location specific documents for Morgan, Tipton, White Memorial, Paoli, and SIP)						
Program	Description	Plan			Pharmacy Network	
		PPO Plan	HSA Plans	HRA Plans	Preferred In-Network: IU Health, Kroger, CVS	Non-Preferred Network
Pharmacy copay/coinsurance → plan deductible	Pharmacy copay/coins count toward the overall plan deductible.	N/A	✓	N/A	✓	✓
Pharmacy copay/coinsurance → plan MOOP	Pharmacy copay/coins count toward the overall plan maximum out of pocket (MOOP).	✓	✓	✓	✓	✓

Emergency Medications

In Emergency situations there are options for filling medications at non-preferred pharmacies for the preferred Copay or Coinsurance when preferred pharmacies are unavailable. This override applies to Emergency prescriptions only, including antibiotics, anti-nausea, asthma rescue medications, and some other short term therapies. This does not include maintenance therapies and regular refills such as blood pressure, cholesterol, and most other prescriptions.

In the event that an IU Health, CVS, or Kroger/Payless Pharmacy is not available for use, ask the pharmacist to call 844.432.0704 so you can fill the prescription at the lower preferred pharmacy copay. The other option for preferred pharmacy copays on emergency prescriptions when IU Health, CVS, or Kroger/Payless Pharmacies are not available is to submit a reimbursement form, which is available at myiuhealthplans.com.

Prescription Drug Coverage Under Medicare

Effective January 1, 2006, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) added a Prescription Drug program to Medicare (Medicare Part D) for individuals who are enrolled in Medicare.

Individuals initially become entitled to Medicare Part A when they reach age 65 and receive Social Security benefits. An individual is eligible for Medicare Part D Prescription Drug Benefits if covered by Medicare Part A and/or enrolled in Medicare Part B or enrolled in a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug Plans provide a standard level of coverage set by Medicare. Some Plans may offer more coverage for a higher monthly premium.

Individuals under age 65 may also become entitled to Medicare benefits if they receive at least 24 months of Social Security benefits based on disability.

IU Health Plans has determined that the Prescription Drug coverage offered is, on average for all Plan participants, expected to pay out as much as standard Medicare prescriptions drug coverage and is therefore considered "creditable coverage". Because IU Health Plans coverage is creditable coverage, you can keep this coverage and not pay a higher premium if you later decide to join a Medicare Prescription Drug Plan. You could be subject to higher Part D premiums, however, if you have a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. Covered Persons can choose not to enroll in a Part D plan or they can enroll in a Part D plan as a supplement to, or in lieu of, the Plan's coverage.

Your Plan coverage pays for other health expenses in addition to Prescription Drugs. If you enroll in a Medicare Prescription Drug plan, you and your eligible Dependents will still be eligible to receive all of your current health and prescription benefits through IU Health Employee Benefits Plan.

If you drop your current medical coverage and enroll in Medicare coverage, you may enroll back into the Plan during an open enrollment period.

Plan enrollees potentially eligible for Medicare Part D include:

- Active working Covered Persons who become Medicare eligible;
- Dependents (such as spouses of active working Covered Persons who are Medicare eligible;
- Disabled Dependents (e.g. children) eligible for Medicare; and
- Long-term disability (LTD) recipients who become Medicare-eligible.

If you become Medicare-eligible, it is important that you evaluate both the Plan Prescription Drug benefit and the Medicare Prescription Drug Benefit to determine which program best meets your specific needs. Compare your current coverage, including which drugs are covered, with the drug coverage and cost of the Plans being offered through Medicare before making a decision to enroll with a Medicare program.

Detailed information about Medicare Prescription Drug Plans is available through:

- Medicare's website at www.medicare.gov;
- Calling Medicare at 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048;

The State Health Insurance Assistance Program (see the inside back cover of the "Medicare and You" handbook for telephone numbers).

Preventive Care

Expanded preventive care screenings and coverage is available without Covered Person cost-sharing when provided by a Network Provider. For a complete list of routine preventive screenings and exams for adults and children, access the Preventive Services link on the Plan website at www.myiuhealthplans.org.

Covered Services mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/preventive-care-benefits/ for more details.

Important Note: The Preventive Care services identified through these links are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered.

Routine preventive screenings that result in abnormal findings may have portions of the service that are considered diagnostic procedures. Applicable Deductibles and Coinsurance will apply to the diagnostic portions of the service. However, services (such as pathology and polyp removal) associated with polyps found during a routine age appropriate colonoscopy will be covered with no cost share.

Routine Patient Costs for Participation in an Approved Clinical Trial

Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Covered Person is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

1. The clinical trial is approved by:
    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The U.S. Food and Drug Administration.
    d. The U.S. Department of Defense.
    e. The U.S. Department of Veterans Affairs.
    f. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services,
2. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

Special Equipment and Supplies

Covered Services shall include Medically Necessary special equipment and supplies including, but not limited to: casts; splints; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; syringes and needles; allergy serums; crutches; oxygen and the administration thereof; soft lenses or sclera shells intended for use in the treatment of Illness or Injury of the eye; Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to Depo-Provera, surgical dressings and other medical supplies ordered by a Provider in conjunction with medical treatment, but not common first aid supplies.

Sterilization

Covered Services shall include elective sterilization procedures for the Covered Person.

Reversal of sterilization is not a Covered Service.

Temporomandibular Joint Dysfunction (TMJ)

Diagnostic, surgical and nonsurgical treatment of temporomandibular joint (TMJ) dysfunction, including orthotic appliances. An orthotic appliance for TMJ is a similar to a mouth guard that pushes the joint into a more proper and less painful position. Orthodontia such as braces is not a Covered Service.

Therapy Services

Therapy services must be ordered by a Physician to aid restoration of normal function lost due to Illness or Injury, for congenital anomaly, or for prevention of continued deterioration of function.

Covered Services shall include:

1. Services of a Physical Therapist for physical therapy, including treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and

neuro-physiological principles and devices. Such therapy is provided to relieve pain, restore function and to prevent disability following Illness, Injury or loss of a body part.
2. Services of a Provider licensed in occupational therapy for treatment by means of constructive activities designed and adapted to promote the restoration of a person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational or vocational therapies (e.g., hobbies, arts and crafts).
3. Services of a Network Provider licensed in speech therapy for speech therapy for correction of speech impairment.

Other Therapy Services – Covered Services shall include:

1. Radiation therapy for the treatment of disease by x-ray, radium or radioactive isotopes.
2. Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.
3. Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases or anesthetics by inhalation.
4. Dialysis treatments of an acute or chronic kidney ailment (renal failure or insufficiency), which may include the supportive use of an artificial kidney machine. This includes hemodialysis and peritoneal dialysis.
5. Cardiac rehabilitation to restore an individual's functional status after a cardiac event. Home programs, ongoing conditioning and maintenance are not covered.
    a. Note: Prior to receiving cardiac rehabilitation services, contact the Plan's Member Services for verification of coverage.
6. Orthoptic Pleoptic Therapy – The treatment of an abnormal condition, such as strabismus, by visual training exercises.
    a. Note: Prior to receiving treatment, contact the Plan's Member Services for verification of coverage.
7. Respiratory/Inhalation Therapy – The introduction of dry or moist gases into the lungs for treatment purposes.

Transplants -- Organ and Tissue

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered Covered Services subject to the following conditions:

1. When the recipient is covered under this Plan, the Plan will pay the recipient's Covered Charges related to the transplant.
2. When the donor is covered under this Plan, the Plan will pay the donor's Covered Services related to the transplant.
3. Expenses Incurred by the donor who is not covered under this Plan according to eligibility requirements will be Covered Charges to the extent that such expenses are covered by the plan.
4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a Covered Service under this Plan.

5. If the transplant is performed more than 75 miles from the patient's residence, Covered Charges shall include charges for transportation and lodging for the covered recipient and one other person (two other persons if the recipient is an eligible Dependent child) to accompany the recipient to and from a Facility and for lodging at or near the Facility where the recipient is confined, with prior approval from the Plan.
    a. Reasonable and necessary lodging and meal expenses are covered up to $200 per day. There is a $10,000 limit for all transportation, lodging and meals per transplant procedure.) Benefits for organ or tissue transplants are payable for Covered Charges Incurred during a transplant benefit period which begins one day before the transplant and ends 364 days after the date of the transplant. After the end of the transplant period, any immunosuppressant drugs shall be payable under the Prescription Drug benefit.
6. Private duty nursing by a registered Nurse or a licensed practical Nurse when recommended by a Physician. (A Nurse who is a family Covered Person of the recipient or who normally lives in the recipient's home is not covered.) Inpatient private duty nursing is covered only if the Hospital's regular staff cannot provide the care needed due to the recipient's condition. (There is a $10,000 limit on all private duty nursing per transplant procedure.)

If a Covered Person's transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Covered transplant procedures include:

- Bone marrow (autologous and allogenic)
- Heart
- Heart/lung
- Intestine
- Lung
- Liver
- Multivisceral
- Pancreas
- Kidney
- Kidney/pancreas
- Cornea.

Transplant Covered Services include:

1. Inpatient and Outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery;
3. Procurement of an organ or tissue;
4. Reasonable and necessary lodging and meal expenses Incurred by the recipient's companion(s) are covered up to $200 per day. (There is a $10,000 limit for all transportation, lodging and meals per transplant procedure.)

5. Private duty nursing by a registered Nurse or a licensed practical Nurse when recommended by a Physician. (A Nurse who is a family Covered Person of the recipient or who normally lives in the recipient's home is not covered.) Inpatient private duty nursing is covered only if the Hospital's regular staff cannot provide the care needed due to the recipient's condition. (There is a $10,000 limit on all private duty nursing per transplant procedure.)
6. Rental of Durable Medical Equipment for use outside the Hospital, limited to the purchase price of the same equipment.
7. Prescription Drugs, including immunosuppressive drugs; oxygen and diagnostic services. After the end of the transplant period (364 days after the date of the transplant), any immunosuppressive drugs shall be payable under the Prescription Drug benefit.
8. Speech therapy, audiotherapy, visual therapy, occupational therapy, physical therapy and chemotherapy. (Speech therapy for voice training or to correct a lisp is not covered.)
9. Services and supplies for high-dose chemotherapy when provided as part of a treatment Plan that includes bone marrow transplantation. (Coverage for high-dose chemotherapy is provided only if the Covered Person is in an FDA-approved Phase III or IV clinical trial and no alternative conventional treatment can be expected to result in an equal or better benefit or outcome.)
10. Surgical dressing and supplies.
11. Home healthcare by healthcare personnel, as recommended by a Physician to provide skilled care to the recipient.

Multiple Transplant Procedures
If a recipient requires more than one covered transplant procedure, the transplant services described in the Organ and Tissue Transplants section will be treated as follows:

- If each transplant is due to related causes, each is considered as a separate benefit if the transplants are separated by at least 90 days. (If the transplants are due to related causes and they are not separated by at least 90 days, then they are considered as one benefit and the limits under Organ and Tissue Transplants Section shall apply to the transplants.)

For questions about the Organ and Tissue Transplants or Multiple Transplant Procedures, contact IU Health Plans Member Services, 800.873.2022 or 317.816.5170.

Urgent Care

An urgent medical problem is an unforeseen Illness or Injury that is not life-threatening but does require prompt evaluation.

If an urgent medical problem occurs and Medical Care cannot be delayed, contact your Primary Care Physician or proceed to any urgent or immediate care Facility for treatment. After receiving care, advise your Primary Care Physician for further follow up care. Familiarize yourself with Urgent Care and immediate care facilities near your home and work so you're prepared when the need arises.

CVS MinuteClinic

The Plan offers Covered Persons another convenient way to access high quality, affordable Medical Care during off-hours and weekends when your Primary Care Physician may not be available. Through collaboration with select CVS MinuteClinic locations, Covered Persons enrolled in the Traditional PPO Medical Plan may receive services– and pay only $20. Covered Persons in the HRA Medical Plan, HSA Medical Plan and HSA Medical Saver Plan can also receive CVS MinuteClinic services and pay the Deductible and Coinsurance.

MinuteClinic services include treatment for common Illnesses (strep throat, sinusitis, infections); minor abrasions, strains, cuts; and skin conditions such as poison ivy.

There are multiple MinuteClinics in Indianapolis and Indiana. Physicians affiliated with IU Health serve as medical directors for many of the Participating MinuteClinic locations, review charts for quality and are available for consultation when needed.

Indiana MinuteClinics are open extended hours. For specific information and locations, consult the Plan website at: myiuhealthplans.com.

Well-Child Care

Well-child Covered Services include:

1. The initial routine newborn examination following delivery when performed in a Hospital by a Physician other than the delivering Physician;
2. Subsequent routine visits by a Physician to the newborn, until the newborn is released from the Hospital; and

Immunizations, TB tine tests and urinalysis, according to preventive guidelines, For a list of preventive services access the preventive services link on the IU Health Plans website at myiuhealthplans.com. Exclusions – Immunizations and office visits for school, camp, travel and sports are not covered.

See Preventive Care services section of this document.

Well Newborn Care

The Plan shall cover well newborn care as part of the mother's Covered Services during the delivery stay. Such care shall include, but is not limited to:

1. Physician services;
2. Hospital services;
3. Circumcision.

Well-Person Care

Covered Services include routine services, including immunizations and physical examinations for Covered Persons age eight and older.

Exclusions – Immunizations and physical examinations required for sports, school, camp, employment, and travel are not covered.

Benefits Plan – Exclusions

Coverage is Not Provided for the Following Services and Supplies

The Plan will not provide coverage for any of the items listed in this section, regardless of Medical Necessity or recommendation of a Physician or Professional Provider.

General Exclusions

1. Charges for any services, supplies or treatment not specifically provided in this Plan.
2. Charges for services, supplies and treatment, which are not Medically Necessary for the treatment of Illness or Injury, or which are not recommended and approved by the attending Physician, except as specifically stated in this Plan, or to the extent that the charges exceed the Customary and Reasonable Amount or exceed the Negotiated Rate as applicable.
3. Any treatment not recommended or approved by a Physician or medical Provider.
4. Any services, supplies or treatment for which the Covered Person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
5. Services provided by a Covered Person of your immediate family, Close Relative or who resides in the same household as the Covered Person.
6. Expenses paid by another Plan.
7. Services received under the following circumstances:
    a. Physician examinations or services required by an insurance company to obtain insurance;
    b. Physical examinations or services required by a governmental agency such as the Federal Aviation Administration, Department of Transportation, and Immigration and Naturalization Services;
    c. Physical examinations or services required by an Employer in order to begin or continue working, unless Clinically Appropriate;
    d. Premarital examinations and associated required testing; or
    e. Physical examinations or screening test for professional school or private school.
8. Services, supplies or treatment provided by a Hospital or institution maintained by the U.S. Government or any agency thereof or any government outside the U.S., or charges for services, treatment or supplies furnished by the U.S, government or any agency thereof or any government outside the U.S., unless payment is legally required.
9. Treatment for any Illness or Injury caused by war and acts of war – whether the war is declared or undeclared – participation in a riot, civil disobedience or insurrection or similar events whether civil or international or any substantial armed conflict between organized forces of a military nature.

10. Treatment for Illness or Injury contracted while in any branch of the armed forces or military service unless payment is legally required.
11. Charges arising from care, supplies, treatment, and/or services that are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions.
12. Expenses reimbursed for which you are entitled to reimbursement through any public program.
13. Services or expenses that are prohibited by law in the area in which you reside at the time the expense is Incurred.
14. Charges for court-ordered treatment that is not Medically Necessary.
15. Charges for services or supplies in connection with an occupational Injury covered by workers' compensation or in conjunction with occupational disease law.
16. Charges for services, supplies, or treatments, which are primarily educational in nature, except as provided in this Plan; charges for services for educational, vocational testing, or training and work-hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.
17. Services of any kind for developmental, diversional, or recreational purposes.
18. Charges associated with telephone consultations, missed appointments, completion of claim forms, or copies of medical records.
19. Expenses associated with custodial, Domiciliary, convalescent or intermediate care.
20. Charges for private-duty nursing, except as provided through the home healthcare benefit.
21. Charges for services Incurred due to complications of leaving the medical Facility against Medical Advice.
22. Charges for environmental control or structural change including a Hospital, home, property or equipment, or Physician charges connected with prescribing an environmental change.
23. Charges for Experimental or Investigational procedures, drugs, devices, or medical treatments.
24. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a Physician, such as television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-Hospital adjustable beds, exercise equipment, personal clothing or comfort items such as diabetic shoes, wigs, or hygiene items. Bathroom convenience items including but not limited to tub rails, handrails and elevated toilet seats.
25. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.
26. Charges for routine services, such as research studies, screening examination, employment physical, or any related charges, such as premarital lab work,

immunizations and other care not associated with treatment or diagnosis of an Illness or Injury, except as stated in this Plan.

27. Care that occurred prior to your Effective Date or after your coverage has been terminated.
28. Charges for professional services billed by a Physician or registered Nurse, licensed practical Nurse or licensed vocational Nurse who is an Employee of a Hospital or any other Facility and who is paid by the Hospital or other Facility for the service provided.
29. Charges for Hospital admission on Friday or Saturday unless the admission is an Emergency situation, or Surgery is scheduled within 24 hours. If neither situation applies, Hospital expenses will be payable commencing on the date of actual Surgery.
30. Charges for Inpatient Room and Board in connection with a Hospital stay primarily for diagnostic tests or therapy, unless it is determined by the Plan that Inpatient care is Medically Necessary.
31. Charges not submitted within the Plan's 180 day filing limit deadline.
32. Charges for Illness or Injury suffered by the Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified under subrogation.
33. Charges arising from care, supplies, treatment, and/or services that are for charge(s) or portion of a charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Medical Coverage Exclusions

1. Expenses solely for cosmetic procedures or complications from cosmetic procedures, except as specifically stated in this Plan.
2. Charges for surgical weight reduction procedures and all related charges, unless the patient has met the Plan's requirements for bariatric Surgery.
3. Charges for non-surgical services, supplies, or treatment except as specifically stated in this Plan, primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs for treatment of any condition or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and Hospital Confinements for weight reduction programs.
4. Charges for or in connection with: treatment of Injury or disease of the teeth; oral Surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; dental implants; temporary bridges; dentures; or periodontia, unless specifically defined elsewhere in this Plan.
5. Charges for treatment of myofacial pain syndrome including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia and intra-oral prosthetic devices.
6. Charges for services, supplies or treatments for the reversal of sterilization procedures.

7. Coverage for service, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation or gamete intrafallopian transfer (GIFT).
8. Charges for services, supplies or treatment for sexual dysfuntion and inadequacy, including medications.
9. Charges for drugs in the hyaluronic acid therapeutic category (i.e. Orthovisc, Euflexxa, Synvisc, Supartz, Hyalgan, Gel-One)
10. Transitioning back to natal gener following gender reassignment language.
11. Revision following gender reassignment surgery except for life-threatening complications or complications which prevent normal physiologic function including cosmetic revisions.
12. Doula services.
13. Non-legend enteral feeding.
14. Charges for refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated in this Plan; dispensing optician's services.
15. Charges for any eye Surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such Surgery; charges for LASIK Surgery.
16. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid or accessories.
17. Charges associated with the rental or purchase of Durable Medical Equipment (DME) when rental expense exceeds purchase price, or for replacement of equipment that is less than five years old or that can be repaired.
18. Sales tax on medical supplies/DME items.
19. Over-the-counter DME products
20. Rehabilitation (lift) chairs.
21. Home defibrillators.
22. Take home supplies.
23. Charges for non-human or artificial organ transplants.
24. Harvesting of human organs or bone marrow when the recipient is not a Plan Covered Person.
25. Charges for expenses related to hypnosis.
26. Massage therapy even if provided by a Physical Therapist.
27. Alternative Care programs, acupuncture, acupressure treatments, primal therapy, rolfing, psychodrama, megavitamin therapy, visual perception training.
28. Charges for homeopathic or holistic medicines or providers or naturopathy.
29. Except as Medically Necessary, treatment of plantar fasciitis, metabolic or peripheral-vascular Illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails. Noncovered services also include cosmetic foot care (meds for toenail fungus, flat feet, nail trimming) for those without conditions mentioned above.
30. Full body CT scans.

31. Quantitative Sensory Testing (QST).
32. Charges for travel or accommodation, whether or not recommended by a Physician, except as specifically provided in this Plan.
33. Travel Clinic and related services (e.g., immunizations, medications).
34. Sclerotherapy for spider veins.
35. Unattended electrical stimulation.
36. Cervical home traction units.
37. Charges for harmful habit appliances, such as appliances to control bruxism (teeth grinding) or thumb guards.
38. Stand-by charges of a Physician.
39. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids and nutritional supplements, except as required by the preventive care mandate of the ACA.
40. Charges for procurement and storage of one's own blood, unless Incurred within three months prior to a scheduled Surgery.
41. Charges for Prescription Drugs that are covered under the Prescription Drug Program or for the applicable Prescription Drug Copayment.
42. Charges for wigs, artificial hair pieces, artificial hair transplants or any drug – prescription or otherwise – used to eliminate baldness.
43. Services provided outside the scope of the Chiropractor license.
44. Charges for services and supplies for human organ transplants of any Provider outside the U.S.
45. Charges Incurred outside the U.S. if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, supplies and treatment.
46. Charges for the cost of materials used in occupational therapy.
47. Charges for services, supplies or treatment by a Physician, Facility or Professional Provider beyond the scope of their license or services, supplies or treatment not recommended by or performed by the appropriate Physician, Facility or Professional Provider.
48. Charges for services, supplies or treatment due to an Illness or Injury that results from engaging in a hazardous hobby. A hobby is hazardous if it is an activity that is characterized by a threat of danger or risk of bodily harm. Hazardous hobbies include: auto racing or any kind of organized vehicular speed or endurance contest on land, water or air and stunt driving or aerobatics demonstration or contest. This exclusion does not apply if the Illness or Injury resulted from being the victim of an act of domestic violence or underlying medical condition and is not the result of participation in any of the activities described above.
49. Charges related to acupuncture or acupressure treatment.]

Behavioral Health Coverage Exclusions

1. Charges for services, supplies, or treatment for behavior or conduct disorders, development delay, learning disorders, mental retardation or senile deterioration. However the initial examination, office visit and diagnostic testing to determine the Illness shall be a covered benefit, subject to the Plan's Deductible and Copayments.
2. Charges for services for bereavement, marital, religious or family counseling.
3. Charges for biofeedback therapy.

4. Services for mental Illnesses that cannot be treated; however, services to determine of the mental Illness is treatable are covered.
5. Services for weight control or reduction not related to a primary Axis I disorder such as Anorexia or Bulimia.
6. Behavior modification programs unless authorized by IU Health Medical Management Department.
7. Report writing and/or court testimony for any purpose.
8. School meetings for any purpose.
9. Telephone counseling or school meetings by Outpatient Behavioral Health practitioners.
10. Charges incurred as the result of any self-inflicted Injury or Illness, unless the self-inflicted Illness or Injury is otherwise covered by the Plan and if the Covered Person's self-inflicted Injury or Illness is the result of a physical or mental condition or being the victim of an act of domestic violence.
11. Custodial Care, nursing home care, rest cures, Domiciliary care regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition.

Section Five:

ELIGIBILITY, CONTINUATION OF COVERAGE, AND TERMINATION PROVISIONS

IU Health Plans has been contracted to provide benefit plan administration to Covered Persons for this self-funded Plan. IU Health Plans provides member services via telephone and online support for questions regarding: benefits, claims processing and claims status, and Network Providers.

At a Glance

The following information may help IU Health Plans to ensure proper claim payment and locating Plan information:

- **Member Services** – Trained member services representatives are available 7 a.m. – 7 p.m. Eastern Time, Monday-Friday at 800.873.2022 or 317.816.5170. The plan website is: myiuhealthplans.com.
- **Accurate Registration –** Make sure that Registration information is correct for each Covered Person by verifying personal information each time you receive healthcare services. Make sure you have a current ID card and the correct ID card is being used, the address information is up-to-date, and the date of birth information is accurate. This ensures timely claim processing. See the section on Identification (ID) Card for additional information.
- **Coordination of Benefits (COB) –** COB is the procedure used to pay healthcare expenses when a Covered Person is covered by more than one Plan. You are responsible for providing the ASO with information pertaining to additional medical benefits that Covered Persons are eligible to receive. The Plan uses this information for determining payment decisions. See Coordination of Benefits section for additional information.
- **Life Event Changes –** Certain changes that affect you and/or your Dependents, such as a marriage, birth or divorce, may result in the need to make changes to your benefits elections and a corresponding change in premium. See section on Change in Family Status/Life Event Changes for additional information.

Eligibility

You are eligible for benefits if you are a full-time (scheduled to work 72 hours per pay period) or part-time (scheduled to work at least 48 hours per pay period) Covered Employee.

Your Dependents eligible for enrollment include:

1. Legally married spouse.
2. Registered domestic partner (same or opposite sex).
3. Children* or children of a registered domestic partner to the end of the month of their 26th birthday or any age if permanently and totally disabled. (A permanently and totally disabled child must have been continuously covered prior to enrolling in the IU Health Employee Benefit Plan.)

4. Dependent children who are required by a qualified medical child support order (QMCSO) to be covered by the Plan and are (1) not claimed as Dependent with the IRS by the Employee and/or (2) do not reside with the Employee may be covered under the Plan in accordance with such QMCSO. A copy of this order must be furnished to Human Resources Shared Services at the time of enrollment and determined to be qualified as set forth below. Covered children who reside outside the service area and are required to be covered by the Covered Person in accordance with a QMCSO are covered at a higher Deductible and Coinsurance for services, but may return to the service area (designated Primary Care Physician) for all routine care for coverage at the lowest Deductible and Coinsurance. Services received are paid per the Plan. (For enrolling Dependents, see section on How You Enroll.)

   *Children include natural or legally adopted children of the Covered Person or of a registered domestic partner, children placed for adoption, stepchild, an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction, and court-appointed legal guardian.

Coverage Options:

1. **Employee Only –** Covers only the Covered Person.
2. **Employee + Children –** Covers the Covered Person and eligible children.
3. **Employee + Spouse (domestic partner) –** Covers the Covered Person and his/her spouse or domestic partner.
4. **Family –** Covers the Covered Person and eligible spouse/domestic partner and eligible Dependents.

Eligibility Verification

New hires and existing Covered Persons enrolling themselves and/or Dependents in medical, dental and/or vision coverage must provide supporting documentation within 31 days of hire or family status change to Human Resources Shared Services or their local Benefits Office for verification of eligibility. Acceptable documentation is outlined below.

If you are enrolling your spouse in medical coverage, you must also complete and submit a Questionnaire for Medical Coverage of a Spouse/Domestic Partner so a determination can be made on whether the spouse is eligible for primary or secondary coverage through the Plan.

Acceptable Supporting Documentation
(All financial information and Social Security numbers should be marked out.)

- Legal Spouse –A copy of the first page of the most recently filed federal income tax return Form 1040 that indicated "married filing jointly" or "married filing separately" (spouses name must appear on the line provided after "married filing separately"). If recently married and have not filed a joint 1040, Covered Person must provide a copy of the recent valid legal or religious marriage certificate/license, which must include date of marriage.
- Registered domestic partner (same or opposite sex) – A copy of the approved IU Health Affidavit of Domestic Partnership.

- Registered domestic partner – certified tax Dependent – A copy of the approved IU Health Affidavit of Domestic Partnership and a copy of the first page of the most recently filed federal income tax return Form 1040 indicating domestic partner as your IRC Section 152 Dependent.
- Child/Adult child up to age 26 – A copy of any one of the following: birth certificate, legal adoption papers, official court order, legal guardianship papers, qualified medical child support order.
- Disabled child over the age of 26 – A copy of any one of the above acceptable documents for any child/adult child, the first page of the most recently filed Form 1040 and a statement from a Physician certifying that the Dependent cannot work to provide self-supporting due to a permanent and total disability.

Acceptable documentation must be provided within 31 days of hire or family status change to Human Resources Shared Services or local Benefits Office for verification of eligibility for an enrolled Dependent for Plan coverage to become effective.

Contact Human Resources Shared Services at (317.962.7900 or 877.849.5724) or your local Benefits Office if you have any questions about the eligibility of any Dependents you would like to enroll for coverage.

Working Spouse/Registered Domestic Partner Rule

Working spouses and registered domestic partners of Covered Persons will, in most situations, be required to join their Employer's group medical coverage for "primary" coverage. They may choose to be covered under the Plan for "secondary" coverage. (Secondary coverage applies only to claims not paid by one's primary Plan.) However, if the working spouse/registered domestic partner's Employer's Plan does not provide either "creditable" coverage (preventive care, major medical and prescription) or pay at least 50 percent of the premium for single coverage, then the spouse/registered domestic partner is eligible to enroll in the Plan for primary coverage.

If the Covered Person's spouse or registered domestic partner is self-employed, retired, unemployed or works for a company that does not provide a creditable level of coverage, he or she may enroll in the Plan for primary coverage. Likewise, the Plan will be primary for the Covered Person and the enrolled spouse/domestic partner if he or she is employed by an IU Health entity.

To enroll a spouse or registered domestic partner in the Plan, you must complete and return the Questionnaire for Medical Coverage of a Spouse/Registered Domestic Partner. The first page of the questionnaire must be completed. If your spouse/registered domestic partner is employed at a non-IU Health entity, verification of the availability of coverage by a representative from that entity's Human Resources department is necessary to determine eligibility for primary coverage through the Plan. The completed form (along with the above spouse/domestic partner required documents) should be returned to IU Health Human Resources Shared Services within 31 days of hire or family status change to Human Resources Shared Services or your local Benefits Office for verification of eligibility.

The Working Spouse/Registered Domestic Partner rule only applies to medical coverage and does not apply to dental, vision or any other Dependent benefits. This provision does not affect eligibility for primary coverage under any medical, dental or vision plans for eligible children.

Special Enrollment Period for Newly Acquired Dependents
If you acquire a new Dependent through birth, adoption, placement for adoption or marriage and submit a change form (along with applicable eligibility documentation) to Human Resources Shared Services within 31 days of this event, coverage for this Dependent will become effective on the date of the birth, adoption, or placement for adoption. You and your eligible spouse/registered domestic partner may also enroll during this special enrollment period for newly acquired Dependents. Coverage for this Dependent will begin the first of the following month. If you wait longer than 31 days, the Dependent and/or you and your eligible spouse/registered domestic partner are considered late enrollees and you must wait until the next annual open enrollment period to apply for coverage. In this case, coverage will not become effective until January 1 following the open enrollment period. If you acquire a new Dependent, you should notify Human Resources Shared Services (317.962.7900 or 877.849.5724) immediately.

Claims for newborns are paid by the Plan as part of the maternity and delivery charge. This does not mean your baby is covered by the Plan for any services or Hospitalization after mother is discharged from the delivery. Contact Human Resources Shared Services or the ASO if you have any questions.

Note: In all cases, you must complete an enrollment form for the newborn and submit it to Human Resources Shared Services or local Benefits Office within 31 days from delivery to ensure there is no break in coverage for your baby. For other newly acquired Dependents, you have 31 days from the date the Dependent is adopted or placed for adoption in which to provide the above mentioned supporting documentation.

Health Benefit Enrollment Process

Newly Hired and Current Covered Persons

When you begin working at an IU Health Facility, you are given an opportunity to enroll in IU Health Employee Benefits Plan. **You must enroll within the first 31 calendar days from the day you are first eligible. If you miss this opportunity, you must wait until the annual benefits open enrollment period.** You may enroll yourself and your eligible Dependents in one of the Plan options. The annual benefits open enrollment period is usually in October-November in the IU Health system.

Another opportunity when enrollment changes may occur is during a "special enrollment" that's triggered when there is a life-changing event, such as a marriage, birth or adoption, divorce, etc. Again, you will have 31 days to complete a special enrollment from the date of the family status change.

If you do not enroll within the 31-day period after your initial eligibility or special enrollment, you may enroll during the next open enrollment, which could be months later. When you enroll

as a newly hired Covered Person within 31 days of your start date, your coverage is effective on the first day of the month after the date you send in the enrollment information. For example: If you are hired on June 2 and send in your enrollment information on or before July 1, your coverage goes into effect July 1. If you send in the enrollment information on July 2, however, your coverage goes into effect August 1. Human Resources Shared Services must receive your enrollment information within the first 31 days.

It takes approximately 15 business days from the time your information is received by Human Resources to the time your benefit selection is processed with the ASO. If you receive Covered Services prior to your enrollment information being processed, your claims may be denied. These claims will be adjusted once your enrollment is completed when the ASO processes your benefit selections data.

Enrollment Application
Enrollment instructions may be obtained from Human Resources Shared Services. Completed enrollment information must be returned to Human Resources Shared Services, not IU Health Plans. Remember to retain a copy of your information for reference.

Plan Premiums
IU Health Employee Benefits Plan shares the premium expense with you for health coverage. Your premium expenses are paid automatically through payroll deduction. Deductions are taken over 26 pay periods. Your premium expenses are paid automatically on a pre-tax basis through the IU Health Pre-Tax Payment of Premium Plan. Please refer to your Covered Person handbook for specific premium information.

IU Health Plans Identification (ID) Card
Your Identification (ID) Card will be mailed to your home directly by IU Health Plans. Covered Persons will receive an ID card that lists each Covered Person. When you receive your ID Card(s), verify that the information is correct.

For new/changing enrollments, promptly submitting your information reduces delays in receiving your ID Cards and helps avoid possible claims issues.

If your ID Card(s) is lost or stolen, you may contact IU Health Plans for a replacement card. Please have the Covered Person's Social Security Number available for the member services representative.

Your ID Card includes the following information:

1. Logos – for your Plan and Provider Network
2. Benefit option you selected;
3. Name of the Covered Person;
4. Covered Person ID number;
5. Group Name;
6. Copayment and Coinsurance requirements;
7. Member Services contact information;

8. Claim submission mailing address;
9. Pharmacy contact information;

Reinstatement of Coverage

If employment is terminated and the Employee returns to active employment within 13 continuous weeks from the date of termination, the service waiting period will be waived and coverage will take effect on the first day the Employee returns to active employment.

Managing Your Enrollment: Change in Family Status or Life Event Changes

You are required to keep the Plan option you selected for the Plan year unless you or your Dependents experience a change in family status.

There are two times at which you may change your Plan coverage (drop coverage entirely, add coverage, or add/drop a Dependent's coverage) outside of scheduled open enrollment. You may do so only:

1. During your initial period of eligibility for coverage; or
2. In response to a qualified life event.

According to Internal Revenue Service guidelines, the following events are considered **qualifying life events** that would trigger an off-cycle time to make certain benefits changes:

1. Changes in legal marital status, including marriage, death of a spouse, divorce, Legal Separation or annulment;
2. Changes in the number of Dependents for reasons that include birth, adoption, placement for adoption, the assumption of legal guardianship, or death;
3. Employment status changes, such as an Employee, spouse or Dependent starts a new job or loses a current job;
4. Work schedule changes, such as a reduction or increase in hours of employment for the Employee, spouse, or Dependent, including a switch between Part-time and Full Time, a strike or lockout, or the beginning or end of an unpaid leave of absence;
5. A Dependent satisfies – or no longer satisfies – the Plan requirements for unmarried Dependents because of age, job status or other circumstances;
6. A qualified medical child support court order (QMCSO), or similar order, that requires health coverage for an Employee's child;
7. The Employee, spouse or Dependent qualifies for Medicare or Medicaid under Title XVIII of the Social Security Act. (If this happens, Plan coverage may be cancelled for that individual.)
8. The call-up of an Employee reservist to active duty.
9. A covered Retiree and their Dependents whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

If a qualifying life event occurs and you wish to make a change to health coverage, you must contact Human Resources. Adjustments to coverage must be consistent with the changes

resulting from the qualifying life event and must be completed within 31 days of the qualifying life event.

Covered Person(s) under another Plan who lose that coverage as a result of one of the life events listed above are eligible to participate in IU Health Employee Benefits Plan.

Continuation of Medical Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) is a federal statute that allows certain Employees and Dependents be provided with the opportunity to continue your group healthcare coverage on a contributory basis under the following circumstances. The extension of coverage applies to almost all Employee health plans providing medical, dental, Prescription Drug, vision or hearing benefits. You will be able to continue coverage through COBRA by paying 102 percent of the costs of the Plan you choose (100 percent of premium cost plus a two percent administration fee) including any portion formerly paid for by your Employer.

Qualifying Events: Who, When, and for How Long
If your Plan coverage terminates, you and your covered Dependents may continue Medical Care coverage for up to 18 months:

- If your employment terminates for any reason, including retirement; or
- If you lose your coverage due to a reduction in your hours of employment; or
- If you or a Dependent becomes disabled within the first 60 days of COBRA continuation, coverage may be continued for an additional 11 months (29 months total).

Your covered Dependents (or domestic partner) may continue such coverage under the Plan for up to 36 months:

- If you die while covered by the Plan; or
- If you and your spouse are divorced, your marriage is annulled or you are legally separated from your spouse; or
- If you become eligible for Medicare; or
- If your Dependent child is no longer eligible for coverage under the Plan.

The 18-month COBRA continuation period may be extended to 29 months from the date of the initial qualifying event if an Employee or qualified family Covered Person is determined to be disabled (for Social Security disability purposes) by the Social Security Administration (SSA) before the end of the first 60 days of COBRA coverage. The individual must notify the COBRA Administrator of this determination within 60 days of the SSA determination and before the expiration of the original 18-month period.

If the covered Employee terminates employment following a FMLA (Family and Medical Leave Act) leave of absence, the event that will trigger COBRA continuation coverage is the earlier of the dates the covered Employee indicates he or she will not be returning to work or the last day of the FMLA leave of absence.

How to Obtain COBRA Coverage
When coverage terminates, the COBRA Administrator will notify qualified beneficiaries within 14 days of being notified by the Plan. Notifications are sent to the last known address. The covered Employee, spouse or covered Dependent must notify the COBRA Administrator in the event of a divorce, Legal Separation or a child becoming an ineligible Dependent, within 30 days of the last occurring event or the date you or your eligible Dependent would lose coverage on account of such event.

Qualified beneficiaries will have 60 days from the date of loss of coverage or the date of COBRA rights notification, whichever occurs later, to elect COBRA benefits. You must complete the enrollment form and return it to the third party administrator, by the 60-day deadline or you will not be allowed to elect coverage. Once the election is made, your status is on hold until the initial premium is received. Once the initial premium is received, coverage will be reinstated.

There is generally a one- to two-week lag time from when the COBRA Administrator processes the first paid premium and the time the time the coverage is reinstated. **You will be able to receive covered care during this lag time. However, be prepared to provide proof of insurance or be prepared to resubmit the claim if denied the first time.**

If you elect to continue any benefits under COBRA, the first payment must be made no later than 45 days of the election to continue coverage. The first payment covers the period beginning with the date the qualifying event occurred through the date the continuation coverage was elected. Thereafter, monthly payments are due on the first of the month and must be paid within the 31-day grace period following the due date. If premiums are not received by the last day of the month for the month in which they are due, coverage will be terminated, retroactively, to the last day of the previous month.

What Causes COBRA Coverage to End?
COBRA continuation coverage would automatically terminate for the following reasons:

1. Written request by the covered individual.
2. Failure to make a timely payment.
3. If, after electing COBRA, the covered individual becomes entitled to Medicare. (For family Covered Persons other than the Employee, the continuation coverage period begins the day in which the Employee becomes entitled to Medicare and extends for 36 months.)
4. When all group Plans are terminated by the Employer and no other is maintained.
5. If, after electing COBRA, the covered individual becomes covered under another group health plan that does not limit or exclude coverage due to a pre-existing condition exclusion.
6. Completion of the COBRA 18-, 29-, or 36-month continuation period.
7. The qualified beneficiary extends coverage for up to 29 months due to disability, and there has been a final determination that the individual no longer is disabled.

COBRA regulations may change from time to time. The extension of coverage will be provided in accordance with current law. Because COBRA rules are complicated, if you have any questions about eligibility, contact Human Resources Shared Services.

Which Plans are Available?
Qualified beneficiaries who lose coverage under Employer group health, dental or vision plans or the healthcare flexible spending account are allowed to elect to continue at the same or lesser level of coverage as provided on the day before the qualifying event. The same tier of coverage (Employee; Employee/Child(ren); Employee/spouse/domestic partner; Family) may be elected or a qualified beneficiary may elect a combination of lesser levels. For example: if your spouse only needs health coverage and the rest of the family needs dental, this would be a possible selection. The premium rates would correspond to the level of coverage selected. Each qualified beneficiary has individual election rights when choosing to continue coverage under COBRA.

COBRA Coverage Options and Monthly Rates
The cost for COBRA coverage is 102 percent of the total rate shown for the option your selected. Please note, this is not the Employee portion of premium, but the whole cost of premium plus two percent.

Military/Non-Military Leave and Pay

IU Health also complies with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and the Indiana Military Family Leave Act. These laws encompass time off and compensation parameters for non-working time granted due to:

- Certain military training/obligations and non-military service obligations;
- Time off allowed for certain family Covered Persons of individuals serving in a military capacity.

These laws enable affected Employees to continue their medical coverage in manner similar to COBRA. All Full- and Part-Time Employees are covered by this policy.

Retiree Health Coverage

[If you retire from IU Health (between the ages of 55-65 years old and are vested in the IU Health retirement plan), you may continue healthcare coverage under the same benefits and terms as any other Covered Person. Your cost will be at least 102 percent of the total cost of the Plan, which varies from year to year. The percentage you pay will increase after the first 18 months following retirement to either 110 percent or 120 percent, depending upon your age at that time. You will not be able to enroll in Retiree health if you did not have healthcare coverage on your last day of active employment prior to retiring.

If you elect at any time to discontinue healthcare coverage as a Retiree, you will not be able to resume coverage at a later date. Your coverage can continue until the first of the month that you become Medicare-eligible, at which time coverage ends. If you select Employee/Spouse

(domestic partner) or Family coverage and your spouse or domestic partner becomes Medicare-eligible before you, your spouse or domestic partner will need to enroll in Medicare Part A and Part B coverage even if you continue to cover them through Retiree coverage. You can also choose to drop a covered spouse or domestic partner when he or she reaches Medicare eligibility. You must make payments for coverage during your eligible time period. Failure to make timely payments will result in termination of coverage retroactive to the month last paid. Because rates and plans change from time to time, discuss your coverage with Human Resources Shared Services at the time you retire, as well as during qualified open enrollment periods after retirement, until you are no longer eligible or do not wish to continue Participating in the Plan.]

Medical Leave/Disability Status

If you are on an approved medical leave of absence for more than six months you may be eligible for Medical Leave/Disability Status. If you are approved for Medical Leave/Disability Status, your coverage may be extended. You must make arrangements for continuation of coverage directly with Human Resources Shared Services. See the section on Disability Insurance for additional information about these benefits.

Leave of Absence
If you go on an approved leave of absence, your coverage may continue. You must make arrangements for continuation of coverage directly with Human Resources Shared Services. See the section on Family and Medical Leave Act (FMLA) regarding approved leaves.

Termination of Coverage

Healthcare coverage may terminate for several reasons. These include:

- IU Health terminates its Plan.
- Failure to pay your premiums in a timely fashion.
- Failure to enroll or re-enroll as required.
- No longer actively at work.
- Becoming ineligible.
- Falsifying your application.
- Dependents become ineligible.

Coverage terminates the last day of the month in which the event occurs. Coverage may terminate sooner for Dependents if the Covered Person dies or is divorced. You may elect to extend coverage if Plan coverage is lost due to one of the COBRA-related provisions mentioned in Continuation of Coverage section.

Special Enrollment Period for Loss of Other Coverage

In the event you or your Dependents decline coverage through the Plan due to the existence of other health coverage, and if such other health coverage is subsequently terminated due to:

1. Loss of eligibility for such coverage (loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of the coverage for causes such as making a fraudulent claim or for misrepresentation); or
2. The termination of any company contributions for such coverage, then you and your Dependent(s) may enroll in the Plan.

You must provide a properly completed enrollment form to Human Resources within 31 days of the loss of other coverage or termination of company contribution. In such case, the Effective Date of coverage will be the first day of the month following receipt of the properly completed enrollment form to Human Resources Shared Services within 31 days.

[Note: If a properly completed enrollment form is not received within 31 days, then you and/or your Dependents(s) are considered a late enrollee and must wait until the next annual open enrollment period to apply for coverage.]

Covered Persons and Dependents who are or become eligible under the State Children's Health Insurance Program (SCHIP) or Medicaid can enroll in an Employer plan (they are otherwise eligible for) within 60 days of the individual (or Dependent) losing eligibility for the Medicaid or SCHIP program or within 60 days of becoming eligible for premium assistance under Medicaid or SCHIP even though the timing falls outside an open enrollment period and the Covered Person previously refused Employer coverage. If you enroll during open enrollment, coverage goes into effect on January 1 following the open enrollment period.

Assistance with Medical, Dental and/or Vision Premiums

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from the Plan or its affiliates but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your Dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact Indiana's Medicaid or CHIP office, 877.438.4479 or visit their website at www.in.gov/fssa/2408.htm. If you live outside of Indiana, contact 877.KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask if there is a program that might help you pay the premiums for an Employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, the Plan is required to permit you and your Dependents to enroll – as long as you and your Dependents are eligible but not already enrolled in the Employer's plan. This is

called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Qualified Medical Child Support Orders (Court-Ordered Dependent Coverage)

Alternate Recipient
An Alternate Recipient is the individual designated as the person to receive healthcare coverage under the QMCSO. An Alternate Recipient shall be treated as a Covered Person for reporting and disclosure purposes, including Form 5500 reporting, receipt of Summary Plan Descriptions and summary annual reports and other communications with Covered Persons.

Notification of Receipt of Child Support Order (QMCSO)
Upon receipt by Human Resources Shared Services of a medical child support order, we will notify the Covered Person and the potential Alternate Recipient that we have received the child support order. The notification shall describe the procedures for determining whether the child support order is a QMCSO as defined in section 609 of the Employee Retirement Income Security Act. The procedures shall permit a potential Alternate Recipient to designate a representative to receive copies of notices with respect to medical child support order. Within a reasonable period of time after receipt of such order, the Plan Administrator shall determine whether such order is a QMCSO.

Procedures to Determine if Medical Child Support Order is a Qualified Medical Child Support Order
Human Resources Shared Services will review the medical child support order or request legal counsel to review the medical child support order to verify the following items are appropriately addressed in the medical child support order and that any other items that must be addressed under the QMCSO procedures are addressed by the order:

1. The medical child support order must create or recognize the existence of an Alternate Recipient's right to receive benefits for which the participants or beneficiary is eligible under the Plan or to assign those rights;
2. The medical child support order must clearly specify the name and last known mailing address of each Alternate Recipient covered by the order and designate to whom any benefits should be paid on behalf of the Alternate Recipient;
3. The medical child support order must specify in a reasonable description the type of coverage to be provided by the Plan to each Alternate Recipient or the manner in which the type of coverage is to be determined, and such coverage must be available under the Plan;
4. The medical child support order must specify that the order applies to this Plan and the period to which the order applies; and

5. The medical child support order must not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

If the Plan Administrator determines the medical child support order satisfies all of the above requirements, then notification, in writing, will be sent to each of the Alternate Recipient(s) and the Covered Person or beneficiary related to such Alternate Recipient(s) that the order is a QMCSO.

If the Plan Administrator determines the order is not a QMCSO, written notification will be sent to each of the Alternate Recipient(s) and the participant beneficiary related to such Alternate Recipient(s) stating the order is NOT a QMCSO and why the order failed to qualify. The Plan Administrator may take any action permitted under the Plan.

Treatment of Alternate Recipient Under Qualified Medical Child Support Order -- Human Resources Shared Services will treat each Alternate Recipient under a QMCSO as a Covered Person under the Plan for all reporting and disclosure requirements imposed by the Employee Retirement Income Security Act.

Cost of Qualified Medical Child Support Order Benefits – The cost of coverage provided under the QMCSO shall be paid by the party designated as responsible for paying for such coverage in the order. In the event the QMCSO does not specify the party responsible for payment for the Alternate Recipient's coverage under the QMCSO, then the Covered Person or beneficiary of the Plan with custody of the Alternate Recipient shall be responsible for paying such coverage. If no participant has custody of the Alternate Recipient, then the participant or beneficiary most closely related to the Alternate Recipient shall be responsible for paying for such coverage. If two or more Covered Persons or beneficiaries are related to the Alternate Recipient equally, then such individuals shall pay for the Alternative Recipient's coverage equally.

Qualified Medical Child Support Order and Medicaid – The Alternate Recipient's eligibility for Medicaid shall not be considered when enrolling the Alternate Recipient in the Plan. The Plan shall comply with the Alternate Recipient's assignment rights under Medicaid, if any.

Payments or Reimbursements under a Qualified Medical Child Support Order – The Alternate Recipient or the Alternate Recipient's custodial parent can be paid or reimbursed for any benefit payments due under the Plan to or on behalf of the Alternate Recipient.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests.
2. The genetic tests of family members of such individual.
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

Section Six:

MEDICAL BENEFITS ADMINISTRATOR FOR THE PLAN

IU Health Plans is the medical benefits administrator for the Plan. IU Health Plans provides member services via telephone and online, and member services representatives respond to questions regarding benefits, claims processing and claim status, Network Providers and travel Networks. In this role, they are responsible for:

1. Covered Person eligibility verification;
2. Benefit coverage determinations;
3. Identification (ID) Cards, their replacement and questions;
4. Primary Care Physician and Network Provider questions;
5. Processing claims;
6. Issuing statements of Explanation of Benefits (EOB);
7. Coordinating benefits if a Covered Person is covered by more than one health Plan;
8. Subrogation processing; and
9. Worker's Compensation coordination.

Specially trained member services representatives will answer questions about your Network; provide additional information about how to receive services; assist you with problems; interpret benefits; process Appeals; check your eligibility; and send you a variety of information upon request. If foreign language service is required, the medical benefits administrator can arrange for this.

We want you to be satisfied with the care and services you receive through IU Health Plans. We encourage your comments and suggestions, and we will work with you to resolve any concerns that may arise. If you are having difficulty with receiving services through the Plan, it is important to let the Member Services team know right away so that you can be assisted promptly.

The contact information is available on your Plan Identification (ID) Card. You can leave a message on the phone number after hours on business days and during the weekend. Your message will be returned by a member services representative on the following business day.

If you are dissatisfied or have been denied coverage for a service you believe to be a covered benefit, you may initiate a complaint with the Plan. Refer to the section on Covered Person Complaint and Appeals Process.

Communication and Service

Answers to questions are available through IU Health Plans website at iuhealth.org or by contacting IU Health Plans Member Services at 800.873.2022 or 317.816.5170 7 a.m. – 7 p.m. Eastern Time, Monday-Friday, excluding holidays.

Effectively Using Your Health Plan

Registration Process and Updated Medical Record

It is important that your Physician's office has you and your Dependents' correct address and telephone number as well as any information about your spouse's Employer and medical insurer. Accurate Registration information helps to ensure that your claim will be paid correctly and in a timely manner. **Remember to bring all applicable health Plan cards with you when you receive medical services. The office staff will verify that information in your medical record is up to date.**

Covered Persons with a workers' compensation case should advise the appointment scheduler at the time the visit is being scheduled that the visit is related to a work Injury. This notification helps ensure proper claim payment through the Worker's Compensation Board of Indiana.

Claims Information

Using Network Providers when receiving Covered Services, allows you, in most instances, to receive care without sending claims or follow-up paperwork to IU Health Plans.

After you receive care and pay any applicable Copayments or Coinsurance, you will receive an Explanation of Benefits (EOB) from IU Health Plans. An EOB is a statement that explains how the claim was paid according to your healthcare coverage and what, if any, amounts you owe.

How to File a Claim

In most cases, the Provider will file claims for you, however, when you do need to submit a claim, you may log on to iuhealth.org to access a claim form. Claims should be submitted to:

IU Health Plans
P.O. Box 627
Columbus, IN 47202-0627

When you receive an Explanation of Benefits (EOB) or a bill for Covered Services, be sure to review it carefully to confirm that you have been billed appropriately. Contact IU Health Plans Member Services if you have questions at 800.873.2022 or 317.816.5170 7 a.m. – 7 p.m. Eastern Time, Monday-Friday excluding holidays.

If you believe the bill is in error, take these steps to remedy the situation:

1. Be sure your doctor's office has a copy of your most current Plan Identification (ID) Card. The office must have your health coverage information in order to file claims accurately and timely. Failure to provide your doctor's office with this information could result in your benefits not being covered.
2. Check to make sure it is a bill. Your Plan or your Provider may send you an Explanation of Benefits (EOB) or another type of statement, which shows that services were received and paid or billed to the Plan.

3. Is the bill for a service not covered under your Plan benefits or equal to your Coinsurance or Copayments for the services? If so, then you are financially responsible for it and need to pay the Provider.
4. Call the Physician's office staff and inquire about the bill. Explain that you are a Covered Person in the Plan and the bill should be sent to the medical benefits administrator for the Plan.

Adverse Benefit Determination
In the event of an Adverse Benefit Determination and a claim for services is denied, the Covered Person will receive written notice of the decision. Refer to the section on Appeals and Complaint Process for the process and associated timelines.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is the process used to pay healthcare expenses when you or an eligible Dependent is covered by more than one healthcare plan, including Medicare. Coordination of Benefits with other sources of coverage helps IU Health achieve cost savings for its Covered Person population by avoiding duplication of payments.

Excess Insurance
If at the time of injury, sickness, disease or disability there is available, or potentially available, any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

COB Process
All enrollees are required to complete the COB process upon enrollment and in January of each year thereafter.

Process for Determining Which Plan is Primary

To determine which health plan is primary, the Plan has to consider both the coordination of benefits provision of the other health plan and which Covered Person of your family is involved in a claim. The primary insurer will be determined by the **first** of the following that applies:

- Non-coordinating plan: If you have another group plan that does not coordinate benefits, it will always be primary.
- Employee: The plan that covers you as an active Employee is always primary and pays before a plan covering the person as a Dependent, laid-off Employee or Retiree.
- Children:
    - Birthday Rule – When your children's healthcare expenses are involved, the Plan follows the "Birthday Rule". The birthday rule states that the health plan of parent with the first birthday in the calendar year is always primary for the children. For example, if your birthday is in January and your spouse's birthday is in March, your Plan will be primary for all of your children. The year does not matter.
    - Gender Rules and other insurer rules – Sometimes a spouse's insurer has other coordination of benefits rules, such as a gender rule, which state's that the father's insurer is always primary. In cases of the gender rule or other specific insurer coordination of benefits rules for children, the Plan will follow the rules of that insurer.
- Children (parents divorced or separated):
    - If the court decree makes one parent responsible for healthcare expenses, that parent's insurer is primary.
        - Note: Claims are reimbursed according to Plan rules (i.e. Network requirements must be followed even if a court decree dictates Plan is primary for children living outside of the Network of Providers.
    - If the court decree gives joint custody and does not mention healthcare, the Plan follows the birthday rule.
    - If neither of those rules applies, the order will be determined in accordance with the Indiana Department of Insurance rule on coordination of benefits.
- Other situations: For all other situations not described previously, the order of benefits will be determined in accordance with the Indiana Department of Insurance rule on coordination of benefits.

How the Medical Benefits Administrator Pays as Primary

If the IU Health Employee Benefit Plan is primary, the Plan will pay the full benefit provided by the Plan as if you had no other coverage, provided it is a covered benefit through the Plan and the IU Health Medical Management Department rules have been followed.

How the Medical Benefits Administrator Pays as Secondary

Based on coordination of benefits (COB), if the IU Health Employee Benefit Plan is secondary, it will pay only if the services are provided through a Provider. As secondary, the medical benefits administrator payments on the Plan's behalf will be based on the balance left after the primary insurer has paid. A copy of the Explanation of Benefits (EOB) from the primary coverage must be submitted to the medical benefits administrator. The medical benefits

administrator will pay no more than that balance. In no event will the medical benefits administrator pay more than it would have paid had the Plan been primary. The medical benefits administrator will pay no more than the "allowable expense" for the healthcare provided. If the allowable expense is lower than the primary coverage's allowable expense, the medical benefits administrator will use the primary coverage's allowable expense. The primary coverage's allowable expense may be less than the actual bill.

1. **The medical benefits administrator will not pay any Copayments or Coinsurance required by the primary coverage.**
2. **The medical benefits administrator will pay only for services covered under your primary plan only if you followed all of the procedural requirements including Prior Authorization and Network rules.**
3. **If an enrollee or Dependent seeks Covered Services through the Plan, applicable Deductibles must be met before the Plan will reimburse as secondary.**

When the enrollee becomes Medicare-eligible at age 65, the Plan will pay as secondary, as if the Covered Person has Medicare Part B, whether or not the Covered Person is enrolled in Medicare Part B. This means that the Plan will only reimburse 20 percent of the Allowed Amount. This does not apply to actively working age 65 or older Employees.

Enforcement of Coordination of Benefits (COB) Provision

The medical benefits administrator will coordinate benefits provided that the medical benefits administrator is informed by you, or some other person or organization, of your coverage under any other source of coverage.

In order to apply and enforce this provision or any provision of similar purpose of any other insurer, it is agreed that:

1. Any person claiming benefits described through the Plan will furnish the medical benefits administrator with any information that is needed.
2. The medical benefits administrator may, without the consent of or notice to any person, release or obtain from any source the necessary information needed to complete the claims adjudication process.

Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provisions or any provision of similar purpose of any Other Plan. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment
If payment is made through any other coverage that the medical benefits administrator should have made under this provision, then the medical benefits administrator has the right to pay whoever is paid under the Plan; the medical benefits administrator will determine the necessary amount under this provision. Amounts so paid are benefits under this Plan and the medical benefits administrator is discharged from liability to the extent of such amounts paid for Covered Services.

Right of Recovery
If the medical benefits administrator pays more for Covered Services than this provision requires, the medical benefits administrator has the right to recover the excess from anyone to or for whom the payment was made. The Covered Person agrees to do whatever is necessary to secure the medical benefits administrator's right to recover the excess amount.

Coordination Disputes
If you disagree with the way the medical benefits administrator has paid a claim, your first attempt to resolve the problem should by contacting IU Health Plans. You must follow the Appeal process outlined in the Coverage Appeals and Complaints Process section.

Section Seven:

CLAIM PROCEDURES; GRIEVANCE AND APPEAL RIGHTS

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim. For the purposes of this section, "Claimant" shall mean any Covered Person or beneficiary submitting a claim to the Plan and thereby seeking to receive Plan benefits.

The availability of health benefit payments is dependent upon Claimants complying with the following:

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the ASO. The Plan Administrator may delegate to the ASO responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The ASO is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the ASO. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an Assignment of Benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final

Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Claimant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, because of this Plan's design Pre-service Urgent Care claims will not be filed with the Plan; Post-service claims will instead be filed after the urgent care is provided.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim."

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

   If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

   Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the ASO within one hundred eighty (180) days of the date charges for the service(s) and/or supplies were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

A Pre-service claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the ASO in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the ASO, together with a Form HCFA or Form UB92:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. The amount of charges, which reflect any applicable PPO re-pricing.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The ASO will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the ASO within forty-five (45) days (forty-eight (48) hours in the case of Pre-service urgent care claims) from receipt by

the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Grievance and Appeal

Members may file a Grievance or Appeal for an Adverse Benefit Determination which is a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on among other things:

1. A determination of an individual's eligibility for coverage (e.g., rescission), or
2. A denial of part of the claim due to the terms of a coverage document regarding Copays, Deductibles, or other cost sharing requirements

Your request for a Grievance or Appeal of an Adverse Benefit Determination may be submitted to:

Medical Grievance or Appeal:

Mail: IU Health Plans
Office of Appeals
P.O. Box 627
Columbus, Indiana 47202-0627

Fax: 812.314.2543
Phone: 800.873.2022 or 317.816.5170

Pharmacy Grievance or Appeal:

Mail: IU Health Plans
Pharmacy Benefit Management
Office of Appeals
950 N Meridian Street, Suite 600
Indianapolis, Indiana 46204

Fax: 855.397.8762
Phone: 866.822.6504

If you need assistance with filing a Grievance or Appeal contact IU Health Plans Member Services at: 800.873.2022 or 317.816.5170 between the hours of 7 a.m. - 7 p.m. ET Monday through Friday, excluding Holidays. Please have the following information ready when you call:

1. Covered Person name
2. Patient's name
3. Covered Person's Health Plan identification number
4. The nature of the Grievance or Appeal

Grievance

You may request a Grievance but it must be requested within One hundred and eighty (180) days from the receipt of the initial Adverse Benefit Determination. Receipt of the Adverse Benefit Determination will be presumed three (3) business days from the date of postmark.

When the Grievance is received, it will be recorded in the Plan's records so that it can be tracked and resolved. A file will be opened and maintained throughout the case resolution, documenting the substance of the Grievance and any action taken. You have the right to submit written comments, documents, or other information related to the Grievance.

You will be mailed an acknowledgment of your Grievance or Appeal request within three (3) business days after receipt by the Plan.

Appeals

If the Grievance was not resolved to your satisfaction, you may Appeal within thirty (30) days from the Grievance decision by writing to the Office of Appeals. Please address your request for an Appeal to the same address as above or call as described above.

You will be mailed an acknowledgement of your Appeal request for review by the Appeal Panel within three (3) business days after receipt by the Plan.

When the Appeal is received, it will be recorded in the Plan's records so that it can be tracked and resolved. A file will be opened and maintained throughout the case resolution, documenting the substance of the Appeal and any action taken. You have the right to submit written comments, documents, or other information related to the Appeal.

The Appeal will be reviewed by the Appeals Panel which in the case of an Appeal regarding Medical Care or treatment, will be composed of one or more individuals who have knowledge of the medical condition, procedure, or treatment at issue. The individuals will be in the same licensed profession as the provider which proposed, refused or delivered the health care, procedure, treatment or service in question and who was not involved in the matter giving rise to the Appeal.

Expedited Grievance and Appeal

IU Health Plans offers the member an expedited Grievance or Appeal for any Urgent Care request that meets the definition of urgent which is: an Adverse Benefit Determination related to an Illness, disease, condition or Injury or a disability that with respect to which if you followed non urgent timelines would seriously jeopardize the member's:

1. Life or health
2. Ability to reach and maintain maximum function

3. In the opinion of the treating Physician or layperson's judgment would subject the Member to severe pain that cannot be adequately treated without the care and treatment that is subject of the Grievance or Appeal.

The timeframe for an expedited review begins when a member or representative of the member, or a practitioner acting on behalf of the member requests an expedited Grievance or Appeal either verbally, by fax, or in writing.

External Review

If you are dissatisfied with our decision of the Appeal, you have the option for certain types of claims; to request External Review by an Independent Review Organization (IRO).The types of claims are limited to those involving medical judgment, including but not limited to the following:

1. Medical necessity denials
2. Appropriateness
3. Health care setting
4. Level of care
5. Effectiveness of a covered benefit
6. Treatment is Experimental or Investigational; or
7. A rescission of coverage

If you choose to request External Review of your Appeal, send a notice in writing one hundred and twenty (120) days from receipt of the Appeal decision. Receipt will be presumed three (3) business days from the date of postmark.

When filing a request for External Review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the External Review. You may submit additional information to the IRO in writing. You will be allowed five (5) business days to submit the additional information you want considered by the reviewer. The decision of the IRO will be binding on the Plan. An expedited process will be available for urgent claims; you will not bear any costs or filing fees associated with the IRO review. You cannot file more than one (1) External Review request for each Appeal.

Grievance and Appeal Decision Timeframes

Grievances and Appeals of Adverse Benefit Determinations will be resolved according to the following time frames:

1. *Pre-Service (Non-Urgent)*: A pre-service Grievance or Appeal is a request to change an Adverse Benefit Determination for care of services in advance of the member obtaining the care of services. IU Health Plans resolves pre-service Grievances or Appeals within fifteen (15) days from receipt of the request at each level of review.

2. *Concurrent*: A concurrent Grievance or Appeal is a request to extend the course of treatment beyond the period of time or number of treatments involving urgent care. IU Health Plans resolves concurrent Grievances or Appeals within twenty-four (24) hours, as long as the Covered Person makes the request at least twenty-four (24) hours prior to the expiration of the prescribed number of time or number of treatments. If the Covered Person submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

    a. If IU Health Plans receives a request from the Covered Person for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post service claim).
    b. Request by Covered Person Involving Rescission. With respect to rescissions, the following timetable applies:
        i. Notification to Covered Person 30 days
        ii. Notification of Adverse Benefit Determination on appeal 30 days

3. *Post Service*: A post service Grievance or Appeal is a request to change an Adverse Benefit Determination for care or services that have already been received by the member. IU Health Plans resolves post service Grievances or Appeals within thirty (30) days from receipt of the request at each level of review.

4. *Expedited (Urgent)*: An expedited Grievance or Appeal is a request to change an Adverse Benefit Determination for an Urgent Care request by the member. IU Health Plans resolves expedited Grievances or Appeals as expeditiously as the medical condition requires but no later than seventy-two (72) hours after the request for review unless the request fails to provide sufficient information to determine whether or not or to what extent, benefits are covered or payable under the plan in which case the member will be notified of the deficiency within the seventy-two (72) hour timeframe.

5. *External Review*: An External Review is an Appeal request to change an Adverse Benefit Determination for certain types of claims if a member is dissatisfied with an Appeal decision. An Independent Review Organization (IRO) will make a determination within fifteen (15) business days after the external Appeal is filed, or for expedited requests, within seventy-two (72) hours after the external Appeal is filed.

Right to Receive Information

For any level of Grievance or Appeal, you are entitled to receive, upon request, reasonable access and copies of all documents relevant to the Grievance or Appeal. Relevant documents include documents or records relied upon in making the decision and documents and records submitted in the course of making the decision. You are entitled to receive, upon request, a copy of the actual benefit provision, guideline, protocol or similar criterion on which the decision was based. You have the right to have billing and diagnosis codes sent to you as well. You may request copies of the information by contacting IU Health Plans Member Services at

800.873.2022 or 317.816.5170 between the hours of 7 a.m. - 7 p.m. ET Monday through Friday, excluding Holidays. You are not required to bear any costs associated with these requests.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Covered Person will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Covered Person may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Covered Person must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Covered Person as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Covered Person, and the violation is not reflective of a pattern or practice of non- compliance.

If a Covered Person believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Covered Person may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Covered Person with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

Designating a Representative

Covered Persons have the right to designate an Authorized Representative to file a Grievance and, if the Grievance decision is adverse to the Covered Person, an Appeal, with the Plan on the Covered Person's behalf and to represent the Covered Person in a Grievance or an Appeal. An Authorized Representative includes:

- A person to whom a Covered Person has given express written consent to represent the Covered Person with respect to a claim for benefits for a Grievance or Appeal;
- A person authorized by law to provide substituted consent for a Covered Person; or
- A family member of the Covered Person or the Covered Person's treating healthcare professional only when the Covered Person is unable to provide consent; or

- Requests for Precertification and other Pre-Service claims or requests by a person or entity other than the Covered Person may be processed without a written authorization if the request or claim appears to the Clinical Appeals Coordinator to come from a reasonably appropriate and reliable source (e.g. Physician's office, individuals identifying themselves as immediate relatives, etc.).

Physical Examinations
Should there be, in the Plan Administrator's discretion, any question as to the Covered Person's health or physical condition, such that the Medical Necessity of care sought by the Covered Person is called into question, the Plan may, at its own expense, have a Physician of its choice perform a physical examination, as necessary to confirm Medical Necessity. Should the Covered Person refuse to comply with said exam, the care may be deemed to be excluded by the Plan, at the Plan Administrator's discretion.

Autopsy
Upon receipt of a claim for a deceased Covered Person for any condition, Sickness, or Injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Covered Person. The request for an autopsy may be exercised only where not prohibited by any applicable law.

Payment of Benefits
Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an Assignment of Benefits, but in any instance may alternatively be made to the Covered Person, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Covered Person be deceased, payment shall be made to the Covered Person's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an Assignment of Benefits occurred.

A. Assignments
Assignment by a Covered Person to the Provider of the Covered Person's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an Assignment of Benefits, if and only if the Provider accepts said Assignment of Benefits as consideration in full for services rendered. If benefits are paid, however, directly to the Covered Person – despite there being an Assignment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Covered Person's responsibility to compensate the applicable Provider(s). The Plan will not be responsible for determining whether an Assignment of Benefits is valid; and the Covered Person shall retain final authority to revoke such Assignment of Benefits if a Provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits

will be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

B. Non U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. Assignment of Benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If Assignment of Benefits is not authorized, the Covered Person is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Covered Person be made. If payment was made by the Covered Person in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Covered Person shall be that amount. If payment was made by the Covered Person using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider shall be subject to, and

shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

C. Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person or Dependent on whose behalf such payment was made.

A Covered Person, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person or by any of his covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

D. Medicaid Coverage

A Covered Person's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the State Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to benefits which are payable under the Plan.

E. Limitation of Action

A Covered Person cannot bring any legal action against the Company or the ASO to recover reimbursement until ninety (90) days after the Covered Person has properly submitted a request for reimbursement as described in this section and all required reviews of the Covered Person's claim have been completed. If the Covered Person wants to bring a legal action against

the Company or the ASO, he/she must do so within three (3) years from the expiration of the time period in which a request for reimbursement must be submitted or he/she loses any rights to bring such an action against the Company or the ASO.

A Covered Person cannot bring any legal action against the Company or the ASO for any other reason unless he/she first completes all the steps in the appeal process described in this section. After completing that process, if he/she wants to bring a legal action against the Company or the ASO he/she must do so within three years of the date he/she is notified of the final decision on the appeal or he/she will lose any rights to bring such an action against the Company or the ASO.

Questions or Concerns

Contact IU Health Plans Member Services at 800.873.2022 or 317.816.5170 between the hours of 7 a.m. - 7 p.m. ET Monday through Friday, excluding Holidays.

Section Eight:

EMPLOYEE'S RIGHTS AND RESPONSIBILITIES

Third Party Recovery, Subrogation and Reimbursement

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person(s) fails to file a claim or pursue damages against:

    a. The responsible party, its insurer, or any other source on behalf of that party.
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
    c. Any policy of insurance from any insurance company or guarantor of a third party.
    d. Workers' compensation or other liability insurance company.
    e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

    the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to

reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the

Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

1. It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Person and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments

due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan.

Minor Status

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation
The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Discrimination is Against the Law

Indiana University Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Indiana University Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Indiana University Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Allison Shelton.

If you believe that Indiana University Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Allison Shelton, Civil Rights Coordinator, Indiana University Health Plans, 950 N Meridian St, Suite 400, Indianapolis, IN 46204, (317) 963-9788 , TTY: (800) 743-3333, Fax (317) 963-9801, ashelton@iuhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Allison Shelton, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

English: ATTENTION: Our Member Services department has free language interpreter services available for non-English speakers. Call 855.413.2432. (TTY: 800.743.3333)

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.413.2432 (TTY: 800.743.3333).

Chinese:注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855.413.2432（TTY: 800.743.3333）。

Burmese:

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 855.413.2432 (TTY: 800.743.3333) သို့ ခေါ်ဆိုပါ။

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855.413.2432 (TTY: 800.743.3333).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855.413.2432 (ATS : 800.743.3333).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855.413.2432 (TTY: 800.743.3333).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855.413.2432 (TTY: 800.743.3333).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855.413.2432 (TTY: 800.743.3333)번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855.413.2432 (телетайп: 800.743.3333).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 855.413.2432 (رقم هاتف الصم والبكم: 800.743.3333).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 855.413.2432 (TTY: 800.743.3333) पर कॉल करें।

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 855.413.2432 TDD/TTY 800.743.3333 uffrufe.

Dutch: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 855.413.2432 (TDD/TTY 800.743.3333).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 855.413.2432 (TTY: 800.743.3333) 'ਤੇ ਕਾਲ ਕਰੋ।

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 855.413.2432（TTY: 800.743.3333）まで、お電話にてご連絡ください。

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a federal law that pertains to group health plans. HIPAA has the following three basic provisions:

- It prohibits an Employer health Plan from imposing pre-existing conditions exclusions on Employees and Dependents, except in limited, specified circumstances and for limited periods of time.
- It prohibits an Employer health Plan from prohibiting enrollment or charging a higher Employee contribution amount or premium because of "health status-related factors."
- It requires an Employer health Plan to allow enrollment for Employees and Dependents who lose coverage under other plans or insurance policies.

HIPAA Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by the Plan to carry out payment, healthcare operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care Provider, a health Plan, your Employer (when functioning on behalf of the group health Plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or Mental Health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact: IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday.

Effective Date

This Notice of Privacy Practices becomes effective on January 1, 2017.

Our Responsibilities

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available by posting on the IU Health Plans website at iuhealth.org.

Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

Payment and Health Care Operations

We have the right to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the

activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

- *Payment* - We will use *or dis*close your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was Medically Necessary.

- *Health Care Operations* - We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

- *Required by Law* - We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

- *Public Health Activities* - We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, Injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- *Health Oversight Activities* - We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

- *Abuse or Neglect* - We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to

receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

- *Legal Proceedings* - We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- *Law Enforcement* - Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

- *Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations* - We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- *Research* - We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

- *To Prevent a Serious Threat to Health or Safety* - Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- *Military Activity and National Security, Protective Services* - Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

- *Inmates* - If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to

provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

- *Workers' Compensation* - We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or Illnesses.

- *Emergency Situations* - We may disclose your PHI in an Emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

- *Fundraising Activities* - We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- *Group Health Plan Disclosures* - We may disclose your PHI to a sponsor of the group health plan – such as an Employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

- *Underwriting Purposes* - We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

- *Others Involved in Your Health Care* - Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

  If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of Your PHI that Require Your Authorization

- *Sale of PHI* - We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

- *Marketing* - We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

- *Psychotherapy Notes* - We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

- *Disclosures to the Secretary of the U.S. Department of Health and Human Services*
  We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

- *Disclosures to You* - We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

  We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

  <u>*Even if you designate a personal representative*</u>, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

- *Business Associates* - We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our ASO, which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy.

- *Other Covered Entities* - We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- *Plan Sponsor* - We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, Mental Health, substance abuse/Chemical Dependency, genetic testing, reproductive rights, etc.

Your Rights

The following is a description of your rights with respect to your PHI.

- *Right to Request a Restriction* - You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide Emergency treatment to you. You may request a restriction by contacting IU Health Plans Member

Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- *Right to Request Confidential Communications* - If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

  You may request a restriction by contacting IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

  We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

  Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.,* an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

  Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within seven business days.

  Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely

important that you contact the designated contact listed on the first page of this Notice *as soon as* you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for *all* your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

- *Right to Inspect and Copy* - You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

  To inspect and copy your PHI that is contained in a designated record set, you must submit your request to IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

  We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

- *Right to Amend* - If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

  In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed

information and all future disclosures of the disputed information will include your statement.

- *Right of an Accounting* - You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

  An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

  You may request an accounting by submitting your request in writing to IU Health Plans, P.O. Box 627, Columbus, IN 47202-2808. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

  Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list.

  We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are Incurred.

- *Right to a Copy of This Notice* - You have the right to request a copy of this Notice at any time by contacting IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

Complaints

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems;

and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Plan Administration

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the ASO to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the ASO, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Covered Person is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered

ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes which may arise relative to a Covered Person's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the SPDs and all other records pertaining to the Plan.
8. To appoint and supervise a ASO to pay claims.
9. To perform all necessary reporting as required by ERISA.
10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with

applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of Covered Persons in accordance with ERISA.

Summary of Material Reduction (SMR)

A Material Reduction generally means any modification that would be considered by the average Covered Person to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than sixty (60) days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Covered Person. The sixty (60) day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next ninety (90) days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within two hundred ten (210) days after the close of the Plan Year in which the changes became effective.

Note: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least sixty (60) days before the effective date of the Material Modification.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a Covered Person of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

A Statement of Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. ERISA provides that Plan Covered Persons shall be entitled to:

Receive Information About the Plan and Benefits

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents that govern the Plan, including any insurance contracts if applicable, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts if applicable, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continuing Plan Coverage

Covered Persons may have the right to continue Plan coverage if you lose coverage on account of a qualifying event. You or your spouse or Dependents may have to pay for the coverage. Review this Summary Plan Description and the SPDs regarding your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of SPDs or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof convening the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim was frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator, Director, Benefits Department, Indiana University Health, 340 West 10th St., P.O. Box 1367, Indianapolis, IN 46202, 317. 962.7900. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Your Patient Rights

Your Right to Decide About Medical Care

You Need to Know…
You can decide, right now, what medical treatments you want or don't want.

You can tell your doctor or loved ones these decisions so that if you become too sick to tell them they'll know what you want them to do.

You can choose someone you trust to make these decisions for you if you become unable to make them for yourself.

You can write these decisions down on a paper called an *advance directive.*

Introduction

You can decide – right now – what treatment you want or don't want, and you can tell that decision to your doctor and your loved ones so that if you become too sick or unable to tell them, they'll know what you want them to do. Federal law now says that you must also be informed of other ways that you can control the medical treatment you receive. That is the

purpose of this section.

What happens if I become unable to make my own medical decisions?

Unless you do something, your healthcare decisions will be made by someone else if you become unable to consent to or refuse medical treatments for yourself. In Indiana, these decisions may be made by whomever your doctor talks to in your immediate family (meaning your spouse, parents, adult child, brother or sister) or by a person appointed by a court.

But in Indiana, you can make and write down your own decisions about future medical treatment if you wish. Or you can appoint a person you choose to make these decisions for you when you are not able to do so. You can even disqualify someone you don't want to make any health decisions for you. You can do these things by having what is called an *advance directive. Advance directives* are documents you can complete to protect your rights to determine your medical treatment and can help your family and doctor understand your wishes about your healthcare.

Your *advance directive* will not take away your right to continue to decide for yourself what you want. This is true even under the most serious medical conditions. Your *advance directive* will speak for you only when you are unable to speak for yourself, or when your doctor determines that you are no longer able to understand enough to make your own treatment decisions.

What can I do now to express my wishes in case I later become unable to tell my doctor or my family?

There are three ways you can make your wishes known now, before you get too sick to tell what treatment you want or don't want:

1. You can speak to your doctor and your family.
2. You can appoint someone to speak or decide for you.
3. You can write some specific medical instructions.

Do I have to fill out more papers?

No. You can always talk with your doctor and ask that your wishes be written in your medical chart. You can talk with your family. You don't have to write down what you want, but writing it down makes it clear, and sometimes, writing it down is necessary to make it legal. When you are no longer able to speak for yourself, Indiana law pays special attention to what you have written in your *advance directive* about your healthcare wishes and whom you appointed to carry them out.

Do I have to decide about an *advance directive* right now?

No. You have a right to make an *advance directive* if you want to, and no one can stop you from doing so. But no one can force you to make an *advance directive* if you don't want to and no one can discriminate against you if you don't sign one.

Which *advance directive* should I use?

That depends on what you want to do. If you want to put your wishes in writing, there are three Indiana laws that are important – the Health Care Consent Act, the Living Will Act, and the Powers of Attorney Act. These laws may be used singularly or in combination with each other.

These laws are complicated, however, and it is always wise to talk to a lawyer if you have specific questions about your legal choices.

What is the Indiana Health Care Consent Act?

The Indiana Health Care Consent Act is found in the Indiana Code at IC 16-36-1. This law lets you appoint someone to say yes or no to your medical treatments when you are no longer able. This person is called your *healthcare representative,* and he or she may consent to, or refuse, medical treatment for you in certain circumstances that you can spell out. To appoint a *healthcare representative,* you must put it in writing, sign it, and have it witnessed by another adult.

Because these are serious decisions, your *healthcare representative* must make them in your best interest. In Indiana, courts have already made it clear that decisions made for you by your *healthcare representative* should be honored. These decisions can determine which medical treatments you will or will not receive when you are unable to express your wishes. If you want, in certain circumstances and in consultation with your doctor, your *healthcare representative* may even decide whether or not food and water should be artificially provided as part of your medical treatment.

What is the Living Will Act?

The Indiana Living Will Act is found in the Indiana Code at IC 16-36-4. This law lets you write one of two kinds of legal documents for use when you have a terminal condition and are unable to give medical instructions. The first, the Living Will Declaration, can be used if you want to tell your doctor and family that life-prolonging medical treatments should not be used, so that you can be allowed to die naturally from your terminal condition. In a Living Will Declaration, you may choose whether or not food or water should be artificially provided as part of your medical treatment or whether someone else should make that decision for you. The second of these documents, the Life-Prolonging Procedures Declaration, can be used if you want all possible life-prolonging medical treatments used to extend your life.

For either of these documents to be effective, there must be two adult witnesses and the document must be in writing and signed by you or someone that you direct to sign in your presence. Either a Living Will Declaration or a Life-Prolonging Procedures Declaration can be cancelled orally, or in writing, or by cancelling or destroying the declaration yourself. The cancellation is effective, however, only when your doctor is informed.

What is the Indiana Powers of Attorney Act?

The Indiana Powers of Attorney Act is found in the Indiana Code at IC 30-5. This law spells out how you can give someone the power to act for you in a lot of situations, including healthcare. You do this by giving this person your power of attorney to do certain things you want this person to do. This person should be someone that you trust. He or she does not have to be an

attorney, even though the legal term for this person you appoint is *attorney in fact*. The person you name as your *attorney in fact* is given the power to act for you in only the ways that you specify. Your power of attorney must be in writing and signed in the presence of a notary public. It must spell out who you want as your *attorney in fact* and exactly what powers you want to give to the person who will be your *attorney in fact* and what powers you don't want to give. Since your *attorney in fact* is not required to act for you if he or she doesn't want to, you may wish to consult with this person before making the appointment.

If you wish, your power of attorney document may appoint the person of your choice to consent to or refuse healthcare for you. This can be done by making this person your *healthcare representative* under the Health Care Consent Act, or by referring to the Living Will Act in your power of attorney document. You can also let this person have general power over your healthcare. This would let him or her sign contracts for you, admit or release you from Hospitals or do other things in your name. You can cancel a power of attorney at any time, but only by signing a written cancellation and having this actually delivered to your *attorney in fact.*

Are there forms to help me write these documents?

Although Indiana law provides limited forms for some of the purposes listed above, these may not be sufficient to accomplish everything you might want. Although these laws do not specifically require an attorney, you may wish to consult with one before you try to write one of the more complicated legal documents described above.

Can I change my mind after I write an *advance directive*?

Yes. As mentioned above, you can change your mind about any of the types of appointments or about the living will. However, you need to make various people aware that you've changed your mind – like your doctor, your family or the person you've appointed – and you might have to revoke your decision in writing. Remember, however, that you can always speak directly to your doctor. But be sure to state your wishes clearly and be sure they are understood.

What if I make an *advance directive* in Indiana and I am hospitalized in a different state, or vice versa?

The law on honoring an *advance directive* in or from another state is unclear. Because an *advance directive* tells your wishes regarding Medical Care, however, it may be honored wherever you are, if it is made known. But if you spend a great deal of time in more than one state, you may wish to consider having your *advance directive* meet the laws of those states, as much as possible.

What should I do with my *advance directive* if I choose to have one?

Make sure that someone, such as your lawyer or a family member, knows that you have an *advance directive* and knows where it is located. You should give a copy of your power of attorney document to the person you have appointed to serve as your *attorney in fact*. You may also decide to ask your doctor or other health care provider to make your *advance directive* a part of your permanent medical record. Another idea would be to keep a second copy of the *advance directive* in a safe place where it can be easily found, and you might keep a small card in

your purse or wallet which states that you have an *advance directive* and where it is located or who your *attorney in fact* is, if you have named one.

Patient Self-Determination Act

Patient Information Packet

Your Plan and the Network Providers respect the wishes of patients and their choices for medical treatment. Each patient has the responsibility to tell his or her doctor of his or her desires. As long as you are able, you will make these decisions with the help of your doctor. Unfortunately, during some Illnesses people are often unable to express their wishes – at the very time when many important decisions need to be made. In this situation it would be helpful to have some written instructions for your doctor to follow.

Federal law now requires that health plans ask certain adult Covered Persons if they have written instructions regarding their healthcare. If they do not, the organizations must provide information to them about choices available under state law. The law does not require you to have written instructions.

If you want to make some written instructions for health care Providers to use should you become unable to communicate, you may complete any of the forms identified below. You can change any of these forms at any time. Your choices will not change the quality of care you will receive. Unless you or these forms advise otherwise, you will receive care that is reasonable considering your condition at the time.

Indiana law permits you to make *advance directives* on one of the following forms:

1. **Appointment of a Health Care Representative**. This form allows you to appoint another adult to make decision about your healthcare, if you are unable. That person is expected to act according to your opinions and desires. If you do not appoint someone, Indiana law says that your spouse, parents, adult siblings and adult children may make these decisions. Because all of these people have the same authority, you may want to appoint one person to avoid any disagreements. (Note: Someone with *power of attorney* does not have the power to make health care decisions unless this is specifically written in the document.)
2. **The Living Will.** If you become "terminally ill" and are expected to die within a short period of time, this completed form would tell your doctor that you don't want to be given artificial treatments to prolong your life.
3. **Life-Prolonging Procedures Declaration.** This form permits you to request the use of life-prolonging procedures that would extend our life, without regard to your condition or chances of recovery.

These documents are not easy to make. You should discuss your choices with your doctors, family and friends. When you have completed an *advance directive* document, give a copy to your doctor for placement in your medical record.

When you are admitted to the Hospital, you (or your family) should provide the Participating

Hospital with a copy of any completed form.

Final Things to Remember:

- You have the right to control what medical treatment you will receive.
- Even without a lawyer or a form, you can always tell your doctor and your family what medical treatments you want or don't want.
- No one can discriminate against you for signing, or not signing, an *advance directive.*
- Using an *advance directive* is, however, your way to control your future medical treatment.

Forms to facilitate the *advance directives* decisions are available on the Plan website.

Section Nine:

MISCELLANEOUS PROVISIONS

Applicable Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA") and the laws of the State of Indiana. The Plan is funded with Employee and/or Employer contributions.

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. Your rights as a Participant in the Plan are governed by the SPDs and applicable State law and regulations. This Plan shall be read in such a way so as to conform with any and all applicable law, regulation or court order (if such a court is of competent jurisdiction). Where necessary, the governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations are deemed to be automatically amended to so conform.

Clerical Error/Delay
Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Covered Persons due to such clerical error will be returned to the Covered Person; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment may be deducted from future benefits payable.

Conformity With Applicable Laws
Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum

requirement. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

Fraud
Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Covered Person acts fraudulently or intentionally makes material misrepresentations of fact. It is a Covered Person's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Covered Person's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Covered Persons being canceled, and such cancellation may be retroactive.

If a Covered Person, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Covered Person of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Covered Person is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Covered Person and their entire Family Unit of which the Covered Person is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered Person whose coverage is being rescinded will be provided a thirty (30) day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings
The headings used in this SPD are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

No Waiver or Estoppel
All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Covered Person.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extend allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Written Notice
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Covered Person or his or her Dependents. See the Recovery of Payments provision for full details.

Statements
All statements made by the Company or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

Any Covered Person who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Binding Arbitration

Note: You are enrolled in a plan provided by your Employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this Binding Arbitration provision applies.

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Covered Person and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Covered Person and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Covered Person waives any right to pursue, on a class basis, any such controversy or claim

against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Covered Person.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Covered Person making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Covered Person and the Plan Administrator, or by order of the court, if the Covered Person and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Section Ten:

DEFINITION OF TERMS

Certain words, phrases or terms used in this Plan shall be defined as follows and shown with an initial capital letter.

Adverse Benefit Determination - A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, or a rescission of coverage.

Affordable Care Act (ACA) - The health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

Allowable Expenses - The Usual and Customary charge for any Medically Necessary, Reasonable, and eligible items of expense, at least a portion of which is covered under a Plan. When some Other Plan pays first in accordance with the COB Process provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Also, when an HMO is primary and the Covered Person does not use an HMO Provider, this Plan will not consider as an Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

Against Medical Advice (AMA) – The act of an individual leaving the care of a medical Facility without proper discharge by a Physician.

Allowed Amount – Negotiated charges for allowed health care services as described in this Plan.

Alternate Recipient – Any child of an Employee or their spouse who is recognized in the Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan.

Ambulatory Surgical Facility – A Facility Provider with an organized staff of Physicians, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by the Plan, which:

4. Has permanent facilities and equipment for the purpose of performing surgical procedures on an Outpatient basis;
5. Provides treatment to Covered Persons by or under the supervision of Physicians and nursing services;
6. Does not provide Inpatient accommodations; and
7. Is not, other than incidentally, a Facility used as an office or clinic for the private practice of a Physician.

Appeal - An oral or written request from a Covered Person, Authorized Representative or Provider to review a previous decision or Grievance again.

Approved Clinical Trial – A phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Covered Person provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of network benefits are otherwise provided under the Plan.

ASO (Administrative Services Only)- An arrangement in which the Plan funds its own employee benefit plan but hires an outside firm to perform specific administrative services, such as claims processing.

Assignment of Benefits - An arrangement whereby the Covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less Deductibles, co-payments and the Coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this SPD, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Covered Person, and are limited by the terms of this SPD. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and Deductibles, co-payments and the Coinsurance percentage that is

the responsibility of the Covered Person, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Covered Person as the sole beneficiary.

Authorized Representative – An individual who the Covered Person has authorized in writing to represent or act on their behalf with regards to a claim. An assignment of benefits does not constitute a written authorization for a Provider to act as an Authorized Representative of a Covered Person.

Behavioral/Mental Health Disorder – An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM (Diagnostic and Statistical Manual of Mental Disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Benefits Period –The period of time specified in the Summary of Benefits during which Covered Services are rendered and benefit maximums are accumulated; the first and last benefit periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

Birthing Center – A Facility that meets professionally recognized standards and all of the following tests:

3. It mainly provides an Outpatient setting for childbirth following a normal, uncomplicated pregnancy, in a home-like atmosphere.
4. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the Facility; (c) laboratory diagnostic facilities; and (d) Emergency equipment, trays, and supplies for use in life-threatening situations.
5. It has a medical staff that (a) is supervised Full Time by a Physician; and (b) includes a registered Nurse at all times when Covered Person are at the Facility.
6. It is not part of a Hospital. It has written agreement(s) with a local Hospital(s) and a local ambulance company for the immediate transfer of Covered Persons who develop complications or who require either pre- or post-natal care.
7. It admits only Covered Persons who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.
8. It schedules Confinements of not more than 24 hours for a birth.
9. It maintains medical records for each Covered Person.
10. It complies with all licensing and other legal requirements that apply.
11. It is not the office or clinic of one or more Physicians or a specialized Facility other than a Birthing Center.

Calendar Year - The 12 month period from January 1 through December 31 of each year.

Substance Abuse – Substance Abuse" shall mean any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational

functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more, of the following, occurring within a twelve month period:
    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household).
    b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
    c. Craving or a strong desire or urge to use a substance.
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).
2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Dependence - "Substance Dependence" shall mean substance use history which includes the following: (1) Substance Abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

Child and/or Children shall mean the Employee's natural Child, any stepchild, legally adopted Child, or any other Child for whom the Employee has been named legal guardian, or an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

CHIP - The Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

Chiropractic Care -- Services as provided by a licensed chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck extremities or other joints, other than for a fracture or Surgery.

Claim Determination Period - Means each Calendar Year.

Claims Processor – The entity contracted by the Employer, which is responsible for the processing of claims for benefits under the terms of the Plan and other administrative services deemed necessary for the operation of the Plan as delegated by the Employer.

Clean Claim - A claim that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Clinically Appropriate/Medically Necessary -- A service, supply, and/or Prescription Drug that is required to diagnose or treat conditions the Plan (administered through the ASO) determines is:

- Appropriate with regard to the standards of good medical practice;
- Not primarily for convenience or the convenience of a Provider or another person; and
- The most appropriate supply or level of service that can be safely provided to the Covered Person. When applied to the care of an Inpatient, this means that the Covered Person's medical symptoms or condition requires that the services cannot be safely or adequately provided as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost-effective compared to alternative Prescription Drugs that produce comparable effective clinical results.

The fact that a Provider may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment Medically Necessary. In making the determination of whether a service or supply was Clinically Appropriate, the Plan Administrator, or its designee, may request and rely upon the opinion of a Physician(s). The determination of the Plan Administrator or its designee could be followed by an External Review, which would be binding.

Close Relative – The Covered Person's spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the Covered Person's spouse.

COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance –The payment the Covered Person owes for services rendered when the Plan coverage is less than 100 percent; Coinsurance is applied to covered expenses after the Deductible(s) have been met, if applicable.

Concurrent Review – A review by the Medical Management Department, which occurs during the Covered Person's Hospital stay or during the course of a prescribed treatment to determine if continued care is Medically Necessary.

Confinement – A continuous stay in a Hospital, Treatment Center, Extended Care Facility, Hospice, or Birthing Center due to an Illness or Injury diagnosed by a Physician. Later stays shall be deemed part of the original Confinement unless there was either complete recovery during the interim from the Illness or Injury causing the initial stay or unless the latter stay results from a cause unrelated to the Illness or Injury causing the initial stay.

Partial Confinement – A period of less than 24 hours of active treatment in a Facility licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services;
2. Treatment of Behavioral/Mental Health
3. Alcoholism treatment;
4. Chemical Dependency treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Copayment/Copay – A cost-sharing arrangement whereby a Covered Person pays a set amount to a Provider for a specific service at the time the service is provided.

Cosmetic Surgery – Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Services /Charges – Charges for medical services, procedures or treatments that are Medically Necessary and covered by the Plan.

Covered Person – A person who has satisfied the Plan's eligibility requirements; applied for coverage; been approved by the Plan; and for whom premium payments have been made and coverage is in effect. Covered Persons are sometimes called "you" and "your".

Custodial Care – Care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting the activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes, but is not limited to:

1. Administration of medication which can be self-administered or administered by a lay person; or
2. Help in walking, bathing, dressing, feeding, or the preparation of special diets.

Room and Board and Extended Care/skilled nursing services are not considered Custodial Care if (1) provided during a stay in an institution for which coverage is available under this Plan, and (2) combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the Covered Person's medical condition.

Deductible – An amount, usually stated in dollars, for which the Covered Person is responsible each benefit period before the Plan starts to pay for health care coverage.

Dependents – For a complete definition, refer to the sections on eligibility and Dependent eligibility.

Developmental Delay – Refers to a lag in acquiring basic skills in children especially when compared to how other children their own age are functioning. Delays in motor skills (ability to walk or ability or hold onto objects), communication skills (hearing and speaking), cognitive/mental skills (visual integration with an inability to understand what is seen, for example, dyslexia) and social skills (responding to the feelings of others).

Diagnosis - The act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

Disease - Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

Domiciliary -- A temporary residence.

Durable Medical Equipment (DME) – Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered Durable Medical Equipment (DME). DME includes, but is not limited to: crutches, wheelchairs, Hospital beds, etc…

Effective Date – The date when a Covered Person's coverage begins under the Plan.

Emergency - A situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably

be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnantindividual, and the unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or, in the case of a pregnant individual, the health of the individual or the unborn child; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
- Examples of Emergency medical conditions include, but are not limited to:
    - Chest pain
    - Stroke/CVA
    - Loss of consciousness
    - Hemorrhage
    - Multiple traumas.

An Emergency condition may or may not result in an Inpatient Hospital admission.

Emergency Services - With respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition.
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee – A person directly involved in the regular business of and compensated for services by the Employer, who is regularly scheduled to work not less than 72 hours per pay period on a full-time status or 48 hours per pay period on a part-time basis.

Employer – The Employer is Indiana University Health.

ERISA- The Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits – As stated under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services;

hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Expedited External Review – A request to change an Adverse Benefit Determination made by the Medical Management Department for care or services that involve a medical condition where a delay would seriously jeopardize the life or health of the Covered Person or his/her ability to regain maximum function.

Experimental/Investigational – Services, supplies, and treatment which do not constitute accepted medical practice within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time the services were rendered. These services, supplies, and treatment are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein.

The Plan Administrator or its designee must make an evaluation of the Experimental/non-Experimental standings of specific technologies. The Plan Administrator or its designee shall be guided by a reasonable interpretation of Plan provisions and information provided by other qualified sources who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The Plan Administrator or its designee will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the Covered Person's informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating Facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is in the research, Experimental, study or Investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety and its efficacy as compared with a standard mans of treatment or diagnosis; or
4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, device, medical treatment

or procedure; or the written informed consent used by the treating Facility or by another Facility studying substantially the same drug, device, medical treatment or procedure.

Explanation of Benefits (EOB) – A statement received by the Covered Person from the ASO after services have been rendered that explains how the bill was paid.

Extended Care/Skilled Nursing Facility – An institution or distinct part thereof, operated pursuant to law and one that meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Illness or Injury, professional nursing services, and physical restoration services to assist Covered Persons to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a registered Nurse (RN) or by a licensed practical Nurse under the direction of an RN.
2. Its services are provided for compensation and under the full-time supervision of a Physician or RN.
3. It provides nursing services 24 hours per day.
4. It maintains a complete medical record on each Covered Person.
5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of Mental and nervous disorders.
6. It is approved and licensed by Medicare.

External Review – A request to change an Adverse Benefit Determination made by the Plan Administrator or Medical Management Department for denial of eligibility or care or services when the Covered Person has exhausted the Plan's internal Appeal process.

Facility – A health care institution which meets all applicable state or local licensure requirements, including freestanding dialysis Facility, a lithotripter center or an Outpatient imaging center.

Family Unit - The Employee and his or her Dependents covered under the Plan.

Final Internal Adverse Benefit Determination - An Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Full time – The Covered Person's regularly scheduled work not less than 72 hours per pay period.

Generic/Generic Drug – A Prescription Drug that is available and generally equivalent to the brand name drug. The drug must meet U.S. Food and Drug Administration (FDA) bioavailability standards.

GINA - The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

Grievance - An expression of dissatisfaction, either oral or written regarding an Adverse Benefit Determination from a Covered Person or Covered Person's Authorized Representative.

Habilitation/Habilitation Services - Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.

HIPAA - The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Aide Services – Those medical services which may be provided by a person, other than a registered Nurse, which are Medically Necessary for the proper care and treatment of a Covered Person.

Home Healthcare Agency – An agency or organization that meets the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one Physician and at least one registered Nurse. It must provide for full-time supervision of such services by a Physician or registered Nurse.
3. It maintains a complete medical record on each Covered Person.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under Medicare.

Hospice – An agency that provides counseling and medical services and may provide Room and Board to a terminally ill Covered Person and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service 24 hours-per-day, seven days a week.
3. It is under the direct supervision of a Physician.
4. It has a Nurse coordinator who is a registered Nurse.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of Hospice services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the Covered Person.
9. It is licensed, if licensing is required.

Hospital – An institution that meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to Hospitals.
2. It is engaged primarily in providing Medical Care and treatment to ill and injured persons on an Inpatient basis at the Covered Person's expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or Injury; and such treatment is provided by or under the supervision of a Physician with continuous 24-hour nursing services by or under the supervision of registered Nurses.

4. It qualifies as a Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.
5. It must be approved by Medicare.

Under no circumstances will a Hospital be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

A Hospital shall include a Facility designed exclusively for rehabilitative services where the Covered Person received treatment as a result of an Illness or Injury.

The term Hospital, when used in conjunction with Inpatient stay for Behavioral/Mental Health or Chemical Dependency, will be deemed to include an institution which is licensed as a Mental Health Hospital or Chemical Dependency rehabilitation and/or detoxification Facility by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Identification (ID) Card – A card provided to individuals having Plan coverage listing the individual's name, group number, and important contact phone numbers to call to verify coverage for health and Prescription services. The Covered Person should carry the ID Card with him/her at all times.

Illness – A bodily disorder or disease of a Covered Person.

Incurred or Incurred Date – With respect to a Covered Person, the date the services, supplies or treatment are provided.

Independent Review Organization (IRO) – An outside entity that is accredited by URAC or a similarly nationally recognized accrediting organization to conduct External Reviews. The Plan Administrator will contract with a minimum of three IROs and assignment of External Reviews will be based upon a rotating assignment methodology.

Injury – A physical harm or disability that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient – A Covered Person who receives healthcare as a registered bed patient in a Hospital or other Facility Provider where a Room and Board charge is made.

Institution - A facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Agency, or any other such facility that the Plan approves.

Late Enrollee - A Covered Person who enrolls in the Plan other than:
1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan.

2. Through special enrollment.

Leave of Absence - A period of time during which the Employee must be away from his/her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

Legal Separation - An arrangement to remain married but live apart, following a court order.

Mastectomy – The Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

Maximum Amount and/or Maximum Allowable Charge - The benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed the following:

1. The Usual and Customary amount.
2. The allowable charge specified under the terms of the Plan.
3. The Reasonable charge specified under the terms of the Plan.
4. The negotiated rate established in a contractual arrangement with a Provider.
5. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Benefit – The maximum amount paid by this Plan for any one Covered Person for a particular Covered Service. The maximum amount can be for a specified period of time such as a calendar year.

The maximum number the Plan acknowledges as a Covered Service. The maximum number relates to the number of:

- Treatments during a specified period of time; or
- Days of Facility stay; or
- Visits by a Home Healthcare Agency.

Medical care – Professional services received from a Physician or another healthcare Provider to treat a condition.

Medical Management – A comprehensive Physician-directed program utilizing registered Nurses to provide education and follow-up to Covered Persons to assure the delivery of

Clinically Appropriate, high quality, and cost-effective healthcare in the most appropriate setting. The IU Health Medical Management Department provides these services.

Medically Necessary – See Clinically Appropriate

Medical Record Review - The process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the

Maximum Allowable Charge according to the Medical Record Review and audit results.

Medicare – The program established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits for the Aged; Part B, Supplementary Medical Insurance Benefits for the Aged; Part C, Miscellaneous provisions regarding all programs; and Part D, Prescription Drug Benefits; and including any subsequent changes or additions to those programs.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA - In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Morbid Obesity – A diagnosed condition in which the body weight is one hundred (100) pounds or more over the medically recommended weight in the most recent Metropolitan Life Insurance Company tables for a person of the same height, age and mobility as the Covered Person, or having a BMI (body mass index) of 40 or higher, or having a BMI of 35 in conjunction with any of the co-morbidities: coronary artery disease, type II diabetes, clinically significant obstructive sleep apnea or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal Medical Management).

Negotiated Rate – The Hospital rate and Physician fee schedule the Network Providers have contracted to accept as payment in full for Covered Charges of the Plan.

Network/Network Provider Organization – An organization that selects and contracts with certain Hospitals, Physicians, and other healthcare Providers to provide services, supplies and treatment to Covered Persons at a Negotiated Rate. The Network Provider Organizations are IU Health Plans Network , Encore Networks, and PHCS Healthy Directions Network.

Network Provider – A Physician, Hospital or ancillary service Provider that has an agreement in effect with the Network Provider Organization to accept a reduced rate for Covered Services rendered to Covered Persons. Network Providers agree to accept the Negotiated Rate as payment in full.

Non-Network Provider – A Physician, Hospital, or other healthcare Provider that does not have an agreement in effect with the Network Provider Organization at the time services are rendered. A Provider not Participating with IU Health Plans, Encore Network or PHCS Healthy Directions.

Nurse – A licensed person holding the degree registered Nurse (R.N.), licensed practical Nurse (L.P.N.) or licensed vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Other Plan shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Covered Person.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Outpatient – A Covered Person shall be considered to be an Outpatient if treated at:

1. A Hospital as other than an Inpatient;
2. A Physician's office, laboratory or x-ray Facility; or
3. An Ambulatory Surgical Facility; and

Out-of-Pocket Maximum – The accrued value of Coinsurance payments that has to be satisfied before Plan reimbursement for Covered Services will be provided in full.

Out-of-State Resident - A Covered Persons living and working outside the State of Indiana where an IU Health Plans Network is not available. (Example: Arizona, Florida, Colorado etc.)

Participating – The status of a Physician or other healthcare Provider that has an agreement to provide healthcare services to Covered Persons of the Plan and accept the Allowed Amount as payment in full.

Participating Pharmacy – Any pharmacy licensed to dispense Prescription Drugs, which is contracted with the pharmacy program offered through the Plan.

Part-time – Covered Persons regularly scheduled to work less than 48 hours per pay period.

Patient Protection and Affordable Care Act (PPACA) - The health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

Pervasive Development Disorders (PDD) – refers to a group of conditions that involve delays, absence or regression of special skills, most notably the ability to socialize with others, to communicate, and to use imagination. Children with these conditions often are confused in their thinking and generally have problems understanding the world around them. There are five types of PDD based on how severe are the symptoms and associated symptoms. The five different types are Autism, Asperger's syndrome, childhood disintegrative disorder, Rett's syndrome and Pervasive Development Disorder not otherwise specified.

Physician – A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is practicing within the scope of his license.

Plan – Refers to the Covered Services and provisions for payment of IU Health Employee Benefits Plan.

Plan Administrator – The Plan Administrator is responsible for the overall operations of the Plan and contracts with other entities for day-to-day management of the Plan. The Plan Administrator is the Employer, IU Health.

Plan Year - A period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

Post-service Claim – Those claims for which services have already been received (claims other than pre-service claims).

Pre-Admission Tests - Those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that:

1. The Covered Person obtains a written order form the Physician.
2. The tests are approved by both the Hospital and the Physician.
3. The tests are performed on an outpatient basis prior to Hospital admission.
4. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

Precertification/Prior Authorization – The process of obtaining approval from Medical Management or Pharmacy Benefits to proceed with receiving a healthcare service or Prescription that is Medically Necessary. Applies to services that are limited or excluded from coverage.

Pregnancy - A physical state whereby an individual presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered a Sickness for the purpose of determining benefits under this Plan.

Prescription Drug (Federal Legend Drug) or Drug – Any medication which by federal or state law may not be dispensed without a prescription order.

Formulary **-** (Listing of covered drugs and criteria (i.e. Quantity, age, gender, limits, Prior Authorization criteria, or other established criteria) required for coverage. *For a complete listing of formulary medications, please refer to myiuhealthplans.com .*

Prescription Quantity Limit – The maximum quantity of specified medications and medication strengths that can be dispensed over a defined day's supply.

Preventive Care – Means certain Preventive Care services.

This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for members supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer.

Primary Care Physician (PCP) – Physicians expert in providing diagnosis and treatment of Illness and provision of preventive care; they also serve as coordinators of the overall care of their patients. A PCP is a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is a general or family practitioner, pediatrician, Mental Health Provider or general internist.

Prior Plan - The coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

Prior to Effective Date or After Termination Date - Dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Provider/Professional Provider – A person or organization responsible for furnishing healthcare services, licensed where required and operating within the scope of the license to provide Covered Services to Plan Covered Persons. Providers include, but are not limited to:

- Audiologist
- Certified Addictions Counselor
- Certified Registered Nurse Anesthetist
- Certified Registered Nurse Practitioner
- Chiropractor
- Clinical Laboratory
- Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
- Dentist
- Dietician
- Dispensing optician
- Midwife
- Nurse (R.N., L.P.N., and L.V.N.)
- Nurse Practitioner
- Occupational Therapist
- Optician
- Optometrist
- Physical Therapist
- Physician
- Physician's Assistant
- Podiatrist
- Psychologist
- Respiratory Therapist
- Speech Therapist

The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by CMS for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

Registration – Process of verifying patient information including name, current address, phone number, benefit Plan, and group number. The Registration process must be completed each time you receive healthcare services.

Residential Treatment - Psychiatry health care provided at a live-in facility to a person with emotional disorders that requires continuous medication and/or supervision or relief from environmental stresses.

Reasonable - "Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider's error or mistake. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) CMS and (c) The Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

To be Reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator.

The Plan Administrator reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Retiree – A former Covered Person who retired from service of the Employer and has met the Plan's eligibility requirements to continue coverage under the Plan as a Retiree. Unless otherwise indicated, as used in this document, the term Covered Person shall include Retirees covered under the Plan.

Retrospective Review – A review by the Medical Management Department after the Covered Person's discharge from a Hospital to determine if, and to what extent, Inpatient care was Medically Necessary.

Room and Board – Room and linen service, dietary service, including meals, Medically Necessary special diets and nourishments, and general nursing services. Room and Board does not include personal items.

Scheduled Benefit or Scheduled Benefit Amount - A specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled Benefits are based upon Covered Expenses not otherwise limited or excluded under the terms of the Plan.

Scheduled Benefit Amounts are determined taking into consideration (but not restricted to) the lesser of the Usual and Customary fee for services and/or supplies, which are deemed to be both Reasonable and Medically Necessary, and:

1. For Inpatient Hospital expenses, the Medicare Diagnosis Related Group ("DRG") scheduled dollar conversion amounts based upon the CMS weighted values.
2. For outpatient Hospital expenses, the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values.
3. For Physicians and other eligible Providers, the lesser of the Scheduled Benefit Amount or 125% of the CMS Reimbursement Schedule for the CMS area.
4. For Ambulatory Surgical Centers (ASC) the lesser of the Scheduled Benefit Amount or 125% of the CMS Reimbursement Schedule for the CMS area.
5. At the Plan Administrator's discretion, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.
6. If the Plan Administrator is unable to determine Scheduled Benefit Amounts utilizing the aforementioned process, it shall, at its sole discretion, determine Scheduled Benefit Amounts considering accepted industry-standard documentation uniformly applied without discrimination to any Covered Person.

Semi-Private – The daily Room and Board charge which a Facility applies to the greatest number of beds in its Semi-Private rooms containing two or more beds.

Service Waiting Period - An interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

Sickness - The meaning set forth in the definition of "Disease."

Specialists/Specialty Care Providers – Physician practices with expertise in a specific medical specialty or sub-specialty.

Surgery –

- The performance of generally accepted operative and other invasive procedures;
- The treatment of fractures and dislocations;
- Usual and related preoperative and postoperative care; or
- Other procedures as reasonable and approved by the Plan.

Treatment Center –

1. An institution which does not qualify as a Hospital, but which does provide a program of effective medical and therapeutic treatment for Chemical Dependency or Mental Health Disorders, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the Physician.
    c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the Covered Person.
    d. It provides at least the following basic services:
        i. Room and Board
        ii. Evaluation and diagnosis
        iii. Counseling
        iv. Referral and orientation to specialized community resources.

Urgent Care – Care received for medical conditions that are unforeseen and require attention within 24 hours. Examples of Urgent Care include, but are not limited to:

1. Minor cuts/lacerations
2. Minor burns
3. Minor trauma
4. Seemingly minor Illnesses that include a high fever
5. Sprains

"USERRA" - The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"Usual and Customary - "Usual and Customary" (U&C) shall mean Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Utilization Review – See Medical Management.

All other defined terms in this SPD shall have the meanings specified in the SPD where they appear.