Health Plans

Indiana University

Employee Benefit Plan

Plan Document and Summary Plan Description

Administered by IU Health Plans

Health Plans

Plan Document and Summary Plan Description for Indiana University Employees

Your Guide to Quality Healthcare Services and Healthier Living

Welcome to IU Health Plans, the health Plan offered to Employees of Indiana University. To help you understand the healthcare services and benefits available to you through this Plan, this Plan Document and Summary Plan Description ("Plan Document") was created and will be updated as necessary.

This Plan Document is the complete health Plan document. There are no other documents to reference when determining Health Plan coverage. 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: iuhealthplans.org.

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;
- 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: 866.895.5975, 7 a.m.-7 p.m. Eastern Time, Monday-Friday or visit our website at: iuhealthplans.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.

Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician ("PCP"). If you do not select a PCP, we may assign one. You have the right to designate any PCP who participates in our network and who is available to accept your or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of the Enrollee Identification Card or refer to our website, iuhealthplans.org. For Children, you may designate a pediatrician as a PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of you Identification Card or refer to our website, iuhealthplans.org.

Notice of Nondiscrimination and Accessibility Requirements

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 IU Health Plans Customer Service at 800.455.9776.

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:

Civil Rights Coordinator
Indiana University Health Plans
950 N Meridian St, Suite 400
Indianapolis, IN 46204
T: 800.455.9776, TTY: 800.743.3333, Fax (317) 963-9801
IUHPlansCompliance@iuhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, IU Health Plans' 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 ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 509F, HHH Building
Washington, D.C. 20201
T: 800.368.1019 TDD: 800.537.7697
Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Pediatric Dental Coverage

This policy does not include pediatric dental services as required under the Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance producer or the Federally Facilitated Exchange (www.healthcare.gov) if you wish to purchase pediatric dental coverage.

Additional Federal Notices

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. A health insurance issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Group Contract. See the Schedule of Benefits for more information.

If you would like more information on WHCRA benefits, call us at the number of the back of your Identification Card or contact your Employer.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your Employer to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limit for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the plan. Also, the plan may not impose Deductibles, Copayment, Coinsurance, and out-of-pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out-of-pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance coverage or group health plan coverage, you may in the future be able to enroll yourself or your Dependents in the Group Contract, if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage), provided that you request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents, provided you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

You or your Dependents may also request enrollment if: (1) you or your Dependent lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP) and such coverage is terminated; or (2) your or your Dependent becomes eligible for a premium subsidy through a state premium assistance program. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or of a premium subsidy eligibility determination.

To request a special enrollment under any of the above circumstance or obtain more information, call us at the telephone number on the back of your Identification Card or contact your Employer.

Notice of Premium Assistance under Medicaid or the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health coverage through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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 your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has 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, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272), or the Indiana Family and Social Service Administration electronically at www.in.gov/fssa or by calling toll-free 1-800-889-9949.

Notices Required by State Law

Notice to Members

Questions regarding your coverage should be directed to:

Indiana University
400 East Seventh Street
Bloomington, IN 47405
Phone: 812-856-1234

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints may be filed electronically at www.in.gov/idoi

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Section One:

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 Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Covered Persons in the Plan to the maximum feasible extent.

General Plan Information

Name of Plan:	**Indiana University Employee Benefit Plan**
Plan Sponsor:	**Indiana University** **400 East Seventh Street** **Bloomington, IN 47405** **Phone: 812.856.1234**
Plan Administrator: **(Named Fiduciary)**	**Indiana University** **400 East Seventh Street** **Bloomington, IN 47405** **Phone: 812-856-1234**
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**

Plan Year:	**January 1 through December 31**
Plan Number:	**501**
Plan Type:	**Medical** **Vision**
Administrative Services Only (ASO):	**IU Health Plans** **950 N. Meridian St., Ste.200** **Indianapolis, IN 46204** **Phone: 866.895.5975** **Fax: (317) 963-9800** **Website: www.iuhealthplans.org**
Participating Employer(s):	**Indiana University**
Agent for Service of Process:	**Indiana University** **Plan Administrator** **400 East Seventh Street** **Bloomington, IN 47405** **Phone: 812-856-1234**

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 Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the University 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, 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.

Discretionary Authority

The Plan Administrator 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 Two:

PLAN CHOICES AND NETWORKS

In 2022, Indiana University Employees will have one (1) IU Health Medical Plan, which is a High Deductible Health Plan (HDHP) that can be paired with a Health Savings Account (HSA-based).

The Indiana University's High Deductible Health Plan (HDHP) provides access to high quality health care through IU Health Plans' Provider Network. Benefits are provided when the member obtains Covered Services from an In-Network Provider. There is no out-of-network coverage under this plan except in the case of an emergency, urgent care when more than 50 miles from home, or for a dependent of an Indiana-Resident employee when the dependent lives out of the state of Indiana for reasons other than medical treatment.

High Deductible Health Plan (HDHP) & Health Savings Account (HSA)

A Member enrolled in an HDHP 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 HDHP 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 Employee and the health Plan each pay a certain percentage of the cost of care until the Member's Out-Of-Pocket Maximum is reached.)

The Health Savings Account benefit is an IRS-qualified feature that provides substantial tax savings and participant flexibility. The University makes an annual contribution to the employee's account, and the employee can decide whether to make contributions above a required minimum. The account is owned by the employee; this means that account balances roll over from year to year, even when an employee leaves the University. The account has the flexibility to be used for current medical expenses or funds can be accumulated in the account to save for future health care expenses including those incurred during retirement. Balances of $1,000 or more may be placed in an array of investment options. Contributions, interest, and investment earnings are not subject to federal, state, or FICA taxes; the University pays the monthly banking fees for the savings account while the employee is enrolled in the HSA portion of the plan.

For information on the Health Savings Account, including contributions, withdrawals, account balances, and investment options, call the Nyhart Company at 800-284-8412 or visit iu.nyhart.com.

Networks When Out of the Service Area

If an urgent medical problem occurs outside the State of Indiana and you want to identify a Provider, look for the toll-free number on the back of your Identification (ID) Card. Remember that any follow up or routine care needs to be delivered by Network Providers for the highest level of benefit. 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: iuhealthplans.org. 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, 866.895.5975 and a member services representative will assist you.

Section Three:

HEALTHCARE COVERAGE

The Plan is committed to providing comprehensive healthcare coverage for all Covered Persons.

The medical benefits through Indiana University are administered by IU Health Plans. IU Health Plans Member Services may be contacted at 866.895.5975.

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: iuhealthplans.org in the provider directory section.

Referrals to Network Specialists for Covered Services are not required. However, coverage is subject to applicable Deductible and Coinsurance. 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), 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

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. 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 Out-of- Network Provider. Deductibles and Coinsurance also apply.

All services provided by Non-Network providers require prior approval to be considered at In-Network levels. When a Non-Network Provider is used, the Member is responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any Deductibles, and/or non-covered charges. Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

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.

Special Circumstances for Providing In-Network Rates for Non-Network Providers

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.
- Covered Services of a covered dependent of an Indiana-Resident employee when the dependent lives out of the state of Indiana for reasons other than medical treatment. Dependent coverage out-of-state includes primary care, when using an affiliated network provider, and urgent care and emergency care covered as an In-Network benefit.

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 Employee Benefit Plan 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 not covered.

Deductible Information for HDHP

Deductible means the specified dollar amount of covered charges that must be paid by the Member before the Plan will begin to pay benefits for the remainder of the calendar year. Benefits are paid according to the date the service is provided, not the date the claim is filed. When one or more family members are covered, the family deductible must be met before services are covered for any member — there is no individual deductible for those enrolled in employee/spouse, employee/child(ren), or family coverage. The family deductible can be satisfied by one or more family members.

High Deductible Health Plan (HDHP)

Medical Benefit Description	HDHP Medical Plan In-Network	HDHP Medial Plan Non-Network
Provider Networks Plan approved referrals are required for payment of certain services. See Prior Authorization listing.	**IU Health Plans**	**Out-of-Network**
Annual Deductible Individual/Family (Calendar Year)	$2,700/$5,400	No Coverage Available
Coinsurance (Chart shows what the Employee pays)	20% (after deductible is satisfied)	No Coverage Available
Annual Out-of-Pocket Maximum (OOPM) (Calendar Year) *- Includes Deductible/Coinsurance* *- Your Plan has a non-embedded Out-of-Pocket which means:* *• If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You.* *• If You also cover Dependents (other family members) under this Plan, the "Family" amounts apply. The "Family" Out-of-Pocket amounts can be satisfied by a family member or a combination of family members. Once the Family Out-of-Pocket is met, it is considered met for all family members.*	$3,400/$6,800	No Coverage Available
Physician Home and Office Services Including, but not limited to, Office visits, office surgeries, allergy serum, allergy injections and allergy testing, diagnostic labs and X-rays.	20% - after deductible	No coverage except in an emergency*
Preventive Care Services Including, but not limited to: • Office Services (e.g. routine exams, well child visits, immunizations, labs, hearing screenings) • Hospital/Alternative Facility* Surgical Procedures (e.g. screening colonoscopy) • Non-surgical Hospital/Alternative Facility* services (pap tests, mammograms, PSA, and other lab services) • Women's contraceptive services such as IUDs, implanted and injectable hormones, & sterilization	0% - No deductible	No coverage except in an emergency*
Dental Services (Accidental) (Only covered when related to accidental dental injury or for certain Members requiring anesthesia)	20% - after deductible	No coverage except in an emergency*

Medical Benefit Description	HDHP Medical Plan In-Network	HDHP Medial Plan Non-Network
Emergency Room for Emergency Care No coverage unless an emergency	20% - after deductible	Paid as In-Network when an emergency*
Urgent Care Facility Including, but not limited to, facility visit, and high cost diagnostics, pharmaceuticals, durable medical equipment/prosthetics and allergy testing	20% - after deductible	Paid as In-Network when more than 50 miles from home*
Maternity Services Covered as any other illness; Screenings for gestational diabetes are covered under the "Preventive Care"	20% - after deductible	No coverage except in an emergency*
Diabetic Equipment, Education, and Supplies	20% - after deductible	No coverage except in an emergency
Behavioral Health Services **Mental Illness and Substance Abuse** Including inpatient facility services (residential MH/SA as covered as inpatient); inpatient professional services; physician home and office services; other outpatient services; outpatient facility @ hospital/alternative care facility*, and outpatient professional services	20% - after deductible	No coverage except in an emergency*
Inpatient and Outpatient Professional Services Including, but not limited to, Medical care visits (1 per day); intensive medical care; concurrent care, consultations; surgery; and administration of general anesthesia and newborn exams	20% - after deductible	No coverage except in an emergency*
Inpatient Facility Services Unlimited days except for: • 60 day limit physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)	20% - after deductible	No coverage except in an emergency*
Outpatient Surgery **Hospital/Alternative Care Facility*** Surgery and administration of general anesthesia	20% - after deductible	No coverage except in an emergency*

Medical Benefit Description	HDHP Medical Plan In-Network	HDHP Medial Plan Non-Network
Outpatient Therapy Services Including physician home and office services; other outpatient services at hospital/alternative care facility* **Maximum Therapy Visits per Plan Year: (Network/Non-Network Combined)** • Physical Therapy, Occupational Therapy, & Speech Therapy – 140 combined visits per calendar year • Manipulation Therapy – 12 visits • Cardiac Rehab – Unlimited • Pulmonary Rehab – Unlimited • Dialysis Treatments – Unlimited • Chemotherapy – Unlimited • Radiation Therapy – Unlimited • Inhalation Therapy – Unlimited **Note:** Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services, regardless of the setting where the services are received.	20% - after deductible	No coverage except in an emergency*
Other Outpatient Services Including, but not limited to: • Inpatient Professional Services • Physician Home and Office Services • Non-surgical Outpatient Services, for example: MRIs, C-Scans, chemotherapy, ultrasounds and other diagnostic outpatient services • Home Care Services • Durable Medical Equipment and Orthotics • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation Programs • Outpatient Laboratory Services • Hospice Care • Ambulance Services	20% - after deductible	No coverage except in an emergency*

Medical Benefit Description	HDHP Medical Plan In-Network	HDHP Medial Plan Non-Network
Human Organ and Tissue Transplants *(This benefit and requirements described below do not apply to cornea and kidney transplants or any covered service related to a covered transplant procedure received prior to or after the Transplant Benefit Period.)*	20% - after deductible	No coverage except in an emergency*
Transplant Benefit Period	Starts one day prior to Covered Transplant Procedure and continues for the applicable case rate/global time period.	No coverage except in an emergency*
Covered Transplant Procedure during the Transplant Benefit Period	20% - after deductible	No coverage except in an emergency*
Transportation and Lodging	Covered, as approved by the Plan, up to a $10,000 benefit limit	Not Covered
Live Donor Health Services	Covered as determined by the Plan	No coverage except in an emergency*

*Alternative Facilities include facilities (free standing or attached to a hospital) that are designated primarily for outpatient services like surgery, diagnostic testing (e.g. MRIs), or therapy/rehabilitation.

*Primary and Urgent Care are paid as In-Network for Out-of-State dependents.

Pharmacy Benefits

Pharmacy benefits are provided through CVS Caremark. Please see separate plan document for prescription coverage details.

The Covered Person pays the Deductible and Coinsurance amounts 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.

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 & Partial Confinement
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.

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 the Plan's Medical Plan 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 iuhealthplans.org.

Referrals 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 payment for Covered Services. If there is no 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 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 Out-of-Network Providers at an In-Network 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 as In-Network, and do not require prospective review.

1. Non-Network anesthesiologist if the operating Facility is a Participating Provider.
2. 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.
3. While confined to a Network Hospital, the Network Physician requests a consultation from the Non-Network Provider.
4. Medically Necessary services, supplies and treatments not available through any Network Provider.
5. Ambulance services.
6. Non-Network assistant surgeon charges if the operating surgeon is a Network Provider.
7. Urgent Care treatment.
8. 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.
9. Covered Services of a covered dependent of an Indiana-Resident employee when the dependent lives out of the state of Indiana for reasons other than medical treatment. Dependent coverage out-of-state includes primary care, when using an affiliated network provider, and urgent care and emergency care covered as an In-Network benefit.

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.

An Out-of-Network Provider can only be used in certain circumstances and does not have an agreement with the Network Provider Organization and has not agreed to the Negotiated Rate when providing Covered Services. 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 Out-of-Network Provider in addition to any applicable Deductible and Coinsurance.

All Covered Services and benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary, a Covered Service, or In-Network and does not guarantee payment. To receive maximum benefits for Covered Services, follow the terms of the Plan, including receipt of care from a Network Provider, and

obtain any required Prior Authorization or Precertification. Contact the Network Provider to be sure that Prior Authorization/Precertification has been obtained. IU Health Plans bases its decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on IU Health's clinical coverage guidelines and medical policy. IU Health Plans may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Benefit Booklet. Benefits for Covered Services are based on the Maximum Allowable Amount for such service. **The Plan's payment for Covered Services will be limited by any applicable Deductible, or Plan Year Limit/Maximum in this Benefit Booklet.**

Allergy

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

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 water, 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.

Attention Deficit Disorder/Attention Deficit with Hyperactivity Disorder (ADD/ADHD)

Coverage is limited to the initial examination, office visit and diagnostic testing to determine the Illness. Treatment is not covered, however medication checks will be covered.

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.

Behavioral/ Mental Health and Chemical Dependency

The Plan covers Behavioral/Mental Health and Chemical Dependency Inpatient Hospital admissions and Outpatient services, supplies, and treatment. Coverage for Inpatient and

Outpatient treatment are provided to the same extent and degree as for the treatment of a physical illness. Inpatient Hospital admissions and specified Outpatient procedures and services are subject to obtaining Prior Authorization from the IU Health Plans Medical Management Department. Obtaining Prior Authorization is the responsibility of both the Physician and the Plan Covered Person. (Refer to the section on Medical Management for additional Prior Authorization information).

Chiropractic Care

Covered Services include an initial or follow up consultation and spinal manipulation, subject to the Maximum Benefit shown on 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 Maximum 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. If services are payable for Non-Network Providers, the Covered Person will be 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.

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 service is provided, not the date the claim is filed.

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 paid by the Member before IU Health HDHP will begin to pay benefits for the remainder of the calendar year. Benefits are paid according to the date the service is provided, not the date the claim is filed. When one or more family members are covered, the family deductible must be met before services are covered for any member — there is no individual deductible for those enrolled in employee/spouse, employee/child(ren), or family coverage. The family deductible can be satisfied by one or more family members.

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; Tests and laboratory examinations;
3. Restorations;
4. Prosthetic services;
5. Oral Surgery;
6. Mandibular/maxillary reconstruction;
7. Anesthesia.

Other Dental services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member who is physically or mentally disabled, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia.

Oral Surgery/TMJ

Subject to Medical Necessity – excludes appliances and orthodontic treatment

Covered at the benefit level of the services billed

Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures).

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 iuhealthplans.org and is subject to change at any time.

Exclusions – Unless otherwise provided, services not covered include:

1. Eye refractions
2. Examinations for the fitting of eyeglasses or contact lenses
3. Dental examinations
4. Premarital examinations
5. 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. The cost for delivering and installing the equipment are also covered.

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 lifesaving/prolonging treatment;
3. Breast prosthesis, whether internal or external, following a mastectomy and four surgical bras per calendar year as required by the Women's Health and Cancer Rights Act. Maximum for Prosthetic devices, if any, do not apply.
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 are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered;

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. Hearing Aids for children age 17 and younger (1 per ear every 36 months);
10. Hearing Aids for adults age 18 and older ($3,000 limit every 5 years for the cost of the hearing aid DME – based on last date of service). DME costs apply toward the plan's deductible and out of pocket maximum. Annual exams covered under applicable Primary Care or Specialist cost share (does not apply to $3,000 limit). Accessories covered under DME benefit (does not apply to $3,000 limit).
11. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
12. Restoration prosthesis (composite facial prosthesis);
13. Wigs (the first one following cancer treatment, one per calendar year).

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; artificial heart implants; penile prosthesis in men suffering impotency resulting from disease or injury; 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. Applicable tax, shipping, postage and handling charges are also covered. 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.

Medically Necessary services which IU Health Plans determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Out-of-Network Provider. Emergency Care rendered by an Out-of-Network or International Provider will be covered as an In Network service and paid at billed charges. Balance billing does not apply. In certain circumstances, Emergency Care received from an Out-of- Network Provider may be approved as an Authorized Service. Members must contact IU Health Plans for authorization prior to the claim being filed. In addition, if a Member is referred to a Hospital Emergency room by Provider, benefits will be provided at the level for Emergency Care. ***Follow-up care is not considered Emergency care.***

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions.

Benefits for Emergency Care include facility costs, Physician services, supplies and Prescription Drugs.

Precertification is not required for Inpatient admissions following Emergency Care. However, the Member must notify IU Health Plans, on behalf of the Plan, or verify that their Physician has notified IU Health Plans of the admission within 48 hours or as soon as possible within a reasonable period of time. When IU Health Plans is contacted, the Member will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered

Medically Necessary. If the Provider does not have a contract with IU Health Plans, the Member will be financially responsible for any care IU Health Plans, on behalf of the Plan, determines is not Medically Necessary.

IU Health Plans must be notified of all Emergency admissions for Behavioral Health services within 48 hours after admission or as soon as possible within a reasonable period of time. Care and treatment provided once Stabilized is no longer considered Emergency Care. Continuation of care from an Out-of-Network Provider beyond that needed to evaluate or Stabilize the condition in an Emergency will not be covered unless IU Health Plans authorizes the continuation of care and it is Medically Necessary.

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.

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. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by IU Health Plans, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider;
6. Therapy services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home;
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.

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. (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment);
5. Counseling services (except bereavement counseling);
6. Inpatient stay at a Hospice;
7. Home health aide;
8. 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.

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, 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.

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.

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, intracutaneus 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 who is a female, a covered female spouse of a covered Employee, or Dependent children.

Maternity services include Inpatient Services, Outpatient Services, Physician Home Visits, and Office Services. These services are used for normal or complicated pregnancy, miscarriage, elective and therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape as recommended by a Provider. The Plan shall cover services, supplies and treatments for elective and Medically Necessary abortions and complications from an abortion.

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

Pregnant and postpartum women 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 866.895.5975 or visit the IU Health Plans website: iuhealthplans.org.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate postpartum period. The Member must complete a Continuation of Care Request Form and submit to IU Health Plans.

> **Note**: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission. If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

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 30 days of birth to be enrolled in the Plan. If this is not accomplished within the first 30 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. In order to enroll for dependent coverage, or add the dependent to existing coverage you will need to submit the changes online in the Employee Center in One. IU within 30 days of the child's birth (even if the employee is currently enrolled in Family or Employee w/ Child(ren) coverage; and pay any contributions for the newborn child to continue as a covered dependent.

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.

Preventive Care

Expanded preventive care screenings and coverage is available without Covered Person cost-sharing when provided by a Network Provider. Go to www.iuhealthplans.org and log into your member portal.

Preventive Care services include: Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Covered Services include Benefits 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 healthcare.gov websites 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.

Preventive Care services include but are not limited to periodic health examinations when provided by a Primary Care Physician or Obstetrician/Gynecologist (OB/GYN) in the Physician's office. Office-based preventive medical services include but are not limited to:

1. Patient history;
2. Physical examination;
3. Vital signs;
4. Height and weight;

5. Breast cancer screening tests, including:
    a. One baseline screening mammography before the age of 40 for Covered Person who is at least 35 years old;
    b. Annual screening mammography if at risk and younger than 40;
    c. Annual screening mammography for Covered Person 40 years old or older;
    d. Any additional mammogram views needed for proper evaluation and ultrasound services, if Medically Necessary.
6. Prostate cancer screening tests (PSA), including:
    a. At least one PSA test annually for an individual who is at least 50 years old;
7. Colorectal cancer screening – Colorectal cancer examinations and laboratory tests are covered for any non-symptomatic individual in accordance with current American Cancer Society Guidelines and will be covered 1 per calendar year, regardless of age;
8. Pelvic examination and PAP test;
9. Rectal examination and fecal occult blood testing (FOBT);
10. Immunizations and inoculations (vaccine and administration of vaccine) based on guidelines of the Advisory Committee on Immunization Practices (ACIP), or at the Plan's discretion, other nationally recognized organizations, such as the American Academy of Pediatrics (AAP) or the Academy of Family Physicians (AAFP);
11. Vision screening for children;
12. Preventive medicine counseling;
13. Prenatal care includes services mentioned above and measurements of uterine size, fetal heart tones (FHT) and urine dipstick for protein and glucose;
14. Well child examinations include services mentioned above, as age appropriate and measurements of head circumference, developmental evaluation and urine dipstick.
15. Women's preventive services as mentioned above and Breast-feeding support, supplies, and counseling, including costs for purchasing specified breast-feeding equipment domestic violence screening and counseling; FDA-approved contraception methods, sterilization procedures and contraceptive counseling; Gestational diabetes screening for all pregnant women; HIV counseling and screening for all sexually active women; Human papillomavirus DNA testing for all women 30 years and older; Sexually transmitted infection counseling for all sexually active women annually; Well-woman visits including preconception counseling and routine low-risk prenatal care from a Network Provider.

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 sharing.

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 male sterilization procedures for the Covered Person or covered spouse.

Reversal of sterilization is not a Covered Service.

Sterilization procedures for women are covered at 100 percent when services are provided by in-Network Providers. See Preventive Care section.

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. When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services or Home Care Services, coverage for these Therapy Services is limited to the following:

1. **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 given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.

   Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

2. **Occupational therapy** — for the treatment of a physically disabled person by means of

constructive activities designed and adapted to promote the restoration of the 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).

Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

3. **Speech therapy** — 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. **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
2. **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.
3. **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage the Plan will not require the Member to receive dialysis treatment at a Network Dialysis Facility if that facility is further than 30 miles from their home. If dialysis treatment is required, and the nearest Network Dialysis Facility is more than 30 miles from the Member's home, the Plan will allow the Member to receive treatment at an Out-of-Network Dialysis Facility nearest to their home as an Authorized Service.
4. **Radiation therapy** for the treatment of disease by x-ray, radium or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
5. **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases or anesthetics by inhalation. Covered Services include but are not limited to: introduction of dry or moist gases into the lungs; non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

6. **Pulmonary rehabilitation** — to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Services.

   Physical Medicine and Rehabilitation Services — A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

   Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

   Non-Covered Services for physical medicine and rehabilitation include, but are not limited to:
   - admission to a Hospital mainly for physical therapy;
   - long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

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, meals 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.

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.
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, audio therapy, 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.

NOTE: There are instances where a Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested.

Under these circumstances, the HLA testing and donor search charges are covered as routine Diagnostic Testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

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 at 866.895.5975.

Urgent Care

All Covered Services obtained at Urgent Care Centers are subject to the Plan Deductible. Urgent Care services can be obtained from a Network or Out-of-Network Provider if more than 50 miles from home. Urgent Care Services received from an Out-of-Network Provider when more than 50 miles from home will be paid as in-network. If a Member experiences an accidental injury or a medical problem, the Plan will determine whether the injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on the diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to: ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an Emergency room at a Hospital. If the Member's Physician is contacted prior to receiving care for an urgent medical problem and the Physician authorizes the Member to go to an Emergency room, care received will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

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 iuhealthplans.org. 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 Manipulation Therapy Services rendered in the home as part of Home Care Services.
22. Charges for services Incurred due to complications of leaving the medical Facility Against Medical Advice.
23. Charges for environmental control or structural change including a Hospital, home, property or equipment, or Physician charges connected with prescribing an environmental change.
24. Charges for Experimental or Investigational procedures, drugs, devices, or medical treatments.
25. Charges for orthopedic shoes (except therapeutic shoes for diabetics); foot support

devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.

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 care received in an Emergency room which is not Emergency Care, except as specified in this document. This includes, but is not limited to suture removal in an Emergency room.
31. 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.
32. Charges not submitted within the Plan's 180 day filing limit deadline for Network Providers, and 365 days for Non-Network Providers.
33. 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.
34. 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.
35. 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 hygiene items. Bathroom convenience items including but not limited to tub rails, handrails and elevated toilet seats.
36. Charges which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Member had applied for Parts A, B and/or D, except, as specified elsewhere in this document or as otherwise prohibited by federal law, as addressed in the

section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, IU Health Plans will calculate benefits as if they had enrolled.

Medical Coverage Exclusions

1. Expenses solely for cosmetic procedures or complications from cosmetic procedures, except as specifically stated in this Plan.
2. Complications directly related to a service or treatment that is a Non-Covered Service under the Plan because it was determined by IU Health Plans, on behalf of the Plan, to be Experimental/Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.
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. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy, unless the treatment provided meets the Administrator’s Medical Necessity criteria.
7. Treatment of telangiectatic dermal veins (spider veins) by any method.
8. Charges for services, supplies or treatments for the reversal of sterilization procedures.
9. 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).
10. Treatment for Human Grown Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by IU Health Plans, on behalf of the Plan, through Prior Authorization.
11. Doula services.

12. Non-legend enteral feeding.

13. Charges for refractions; orthoptics; vision orthoptic training; eyeglasses or contact lenses, except as specifically stated in this Plan; dispensing optician's services.

14. 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.

15. 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.

16. Over-the-counter DME products

17. Rehabilitation (lift) chairs.

18. Home defibrillators.

19. Take home supplies.

20. Charges for non-human or artificial organ transplants.

21. Harvesting of human organs or bone marrow when the recipient is not a Plan Covered Person.

22. Charges for expenses related to hypnosis.

23. Massage therapy even if provided by a Physical Therapist.

24. Alternative Care programs, acupuncture, acupressure treatments, primal therapy, rolfing, psychodrama, megavitamin therapy, visual perception training.

25. Charges for homeopathic or holistic medicines or providers or naturopathy.

26. 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. Non-covered services also include cosmetic foot care (meds for toenail fungus, flat feet, nail trimming) for those without conditions mentioned above.

27. Charges for 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.

28. Full body CT scans.

29. Quantitative Sensory Testing (QST).

31.Charges for travel or accommodation, whether or not recommended by a Physician, except as specifically provided in this Plan.

32.Travel Clinic and related services (e.g., immunizations, medications).

33.Unattended electrical stimulation.

34.Cervical home traction units.

35.Charges for harmful habit appliances, such as appliances to control bruxism (teeth grinding) or thumb guards.

36.Stand-by charges of a Physician.

37.Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids and nutritional supplements, except as required by the preventive care mandate of the ACA.

38.Charges for procurement and storage of one's own blood, unless Incurred within three months prior to a scheduled Surgery.

39.Charges for Prescription Drugs that are covered under the Prescription Drug Program or for the applicable Prescription Drug Copayment.

40.Charges for wigs, artificial hair pieces, artificial hair transplants or any drug –prescription or otherwise – used to eliminate baldness, unless otherwise listed as covered.

41.Services provided outside the scope of the Chiropractor license.

42.Charges for services and supplies for human organ transplants of any Provider outside the U.S.

43.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.

44.Charges for the cost of materials used in occupational therapy.

45.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.

46.Charges related to acupuncture or acupressure treatment.

Behavioral Health Coverage Exclusions

1. Charges for services for marital or religious counseling.
2. Charges for biofeedback therapy.
3. Services for weight control or reduction not related to a primary Axis I disorder such as Anorexia or Bulimia.
4. Report writing and/or court testimony for any purpose.
5. School meetings for any purpose.
6. School meetings by Outpatient Behavioral Health practitioners.

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 Four:

EYEMED - VISION COVERAGE

This section describes the Covered Services available under the EyeMed Vision benefit when provided and billed by eligible Providers. This vision benefit is subject to the same general and other provisions as the medical benefits.

The vision benefit is a "carve-out" benefit meaning that it is included in the member's enrollment in the medical plan, but the covered vision services have their own schedule of benefits and network providers separate from medical benefits. That is, the medical plan deductibles and co-insurance do not apply to vision benefits, and the amount the member pays for vision services do not accumulate toward the medical plan deductible or out-of-pocket maximums. Network vision providers can be found using the Provider Locator on www.eyemed.com and choose the INSIGHT network or call 1-866-804-0982.

The vision benefit is for routine eye care and corrective eye care only. For medical treatment of the eyes, visit a medical network eye care physician. Medical eye care includes services for such conditions as eye injuries, glaucoma, and retinal detachment. The medical deductible and out- of-pocket maximums apply to medical eye services.

All Covered Services are subject to the exclusions listed in the Vision exclusion section and all other conditions and limitations of the plan booklet. The amount payable for Covered Services varies depending on whether services are received from a Network Provider or an Out-of-Network Provider and whether or not optional services and/or custom materials are selected rather than standard services and supplies. Payment amounts are specified in the Benefit Summary.

The following are Covered Services:

- Routine vision examination once a year per member
- Standard eyeglass frames and lenses
- Non-elective contact lenses
- Elective contact lenses chosen instead of eyeglasses

Optional savings are available from In-Network providers for additional eyeglasses and certain elective upgrades such as multifocal, photochromatic, tinted, and coated lenses.

Services and materials obtained through an Out-of-Network Provider are subject to the same exclusions and limitations as services through a Network Provider.

Vision Eye Examination

The Plan covers a comprehensive eye examination including dilation as needed minus any applicable co-payment. The eye examination may include the following:

- Case history
- Recording corrected and uncorrected visual acuity
- Examination of the internal and external eye
- Pupillary reflexes
- Binocular vision
- Objective refraction and subjective refraction
- Glaucoma test
- Slit lamp exam (biomicroscopy)
- Dilation
- Color vision
- Depth perception
- Diagnosis and treatment plan

Definitions

Elective Contact Lenses - All prescription contact Lenses that are cosmetic in nature or Non-Elective Contact Lenses.

Lenses - Materials prescribed for the visual welfare of the patient. Materials would include single vision, bifocal, trifocal or other more complex lenses.

Non-Elective Contact Lenses – Contact Lenses which are provided for reasons that are not cosmetic in nature. Non-Elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:

- Extreme visual acuity or other functional problems that cannot be corrected by spectacle Lenses; or
- ***Keratoconus*** – unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years
- ***High Ametropia*** – unusually high levels of near sightedness, far sightedness, or astigmatism are identified; or
- ***Anisometropia*** – when one eye requires a much different prescription than the other eye.

Benefit Summary

	Member Responsibility	
MEDICAL SERVICE/PROCEDURE	**In-Network**	**Out-of-Network**
Routine eye exam (once every plan year)	$10 copay, then covered in full	Up to $42 allowance
Eyeglass frames Once every plan year you may select an eyeglass frame and receive an allowance toward the purchase price	$110 allowance then 20% off any remaining balance	$55 allowance
Eyeglass lenses (Standard) Once every plan year you may receive any one of the following lens options:	$20 copay then covered in full	
Standard plastic single vision lenses (1 pair)		Up to $40 allowance
Standard plastic bifocal lenses (1 pair)		Up to $60 allowance
Standard plastic trifocal lenses (1 pair)		Up to $80 allowance
Standard plastic lenticular lenses (1 pair)		$55 allowance
Eyeglass lens enhancements When obtaining covered eyewear from an EyeMed vision provider, you may add any of the following lens enhancements at no extra cost: Transitions Lenses (for a child under age 19) Standard Polycarbonate (for a child under age 19) Factory Scratch Coating	$0 after eyeglass lens copay	No allowance on lens enhancements when obtained Out-of-Network
Contact lenses (once every plan year) You may choose contact lenses instead of eyeglass lenses and receive an allowance toward the cost of a supply of contact lenses	N/A	N/A
Elective Conventional Lenses	$110 allowance, then 15% off any remaining balance	Up to $88 allowance
Elective Disposable Lenses	$110 allowance, (no additional discount)	Up to $105 allowance
Non-Elective Contact Lenses	Covered in full	$210 allowance
Your contact lens allowance can only be applied toward the first purchase of contacts you make during a benefit period. Any unused amount remaining cannot be used for subsequent purchases made during the same benefit period, nor can any unused amount be carried over to the following benefit period.		

	Member Responsibility	
MEDICAL SERVICE/PROCEDURE	**In-Network**	**Out-of-Network**
Retinal Imaging (at member's option can be performed at time of eye exam)	Not more than $39	Not Covered
Eyeglass lens upgrades When obtaining eyewear from a EyeMed Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.		
Transitions lenses (Adults)	$75	Not Covered
Standard Polycarbonate (Adults)	$40	Not Covered
Tint (Solid and Gradient)	$15	Not Covered
UV Coating	$15	Not Covered
Progressive Lenses *(Please ask your provider for his/her recommendation as well as the progressive brands by tier.)*		
Standard	$65	Up to $40
Premium Tier 1	$85	Up to $40
Premium Tier 2	$95	Up to $40
Premium Tier 3	$110	Up to $40
Anti-Reflective Coating *(Please ask your provider for his/her recommendation as well as the coating brands by tier)*		
Standard	$45	Not Covered
Premium Tier 1	$57	Not Covered
Premium Tier 2	$68	Not Covered
Other Add-ons and Services	20% off retail price	Not Covered
Additional pairs of eyeglasses - Anytime from any EyeMed Vision network provider		
Complete Pair	40% off retail price	Not Covered
Eyeglass materials purchased separately	20% off retail price	Not Covered
Eyewear accessories Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price	Not Covered

	Member Responsibility	
MEDICAL SERVICE/PROCEDURE	**In-Network**	**Out-of-Network**
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.		Not Covered
Standard contact lens fitting *(A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.)*		Not Covered
Premium contact lens fitting *(A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.)*	Up to $55 – 10% off retail price	Not Covered
Conventional contact lenses (discount applies to materials only)	15% off retail price	Up to $105
Laser vision correction surgery LASIK refractive surgery (For more information, call 1-877-5LASERS or visit www.eyemedlasik.com.)	Discount per eye	Not Covered

Exclusions

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of items considered not to be Covered Services. EyeMed is the final authority for determining if services or supplies are Covered Services.

Vision benefits are not provided for these services, supplies or charges:

1. Received from an individual or entity that is not a Provider, as defined in this plan.
2. For any condition, disease, defect, aliment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
4. For illness or injury that occurs as a result of any act of war, declared or undeclared.
5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. Received from an optical or medical department maintained by or on behalf of an employer mutual benefit association, labor union, trust or similar person or group.
8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
9. For completion of claim forms or charges for medical/vision records or reports unless otherwise required by law.
10. For missed or canceled appointments.
11. In excess of Maximum Allowable Amount.
12. Incurred prior to your Effective Date.
13. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
15. For sunglasses and accompanying frames.
16. For safety glasses and accompanying frames.
17. For inpatient or outpatient hospital vision care.
18. For Orthoptics or vision training and any associated supplemental testing.
19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive value or potential).
22. For medical or surgical treatment of the eyes.
23. For lost or broken Lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Certificate.
25. Certain brands on which the manufacturer imposes a no discount policy.
26. For services or supplies combined with any other offer, coupon or in-store advertisement.
27. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery including but not limited to cataract surgery, or for soft contact lenses due to a medical condition.

Claims And Claims Appeals

Time Frames for Processing Claims

First American Administrators, Inc., a third-party administrator and wholly owned subsidiary of EyeMed (hereinafter "FAA") will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written

notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Using Out-of-Network Providers
For services received from an Out-of-Network Provider, members are responsible for making sure a claim is filed in order to receive benefits. If services are obtained from an Out-of-Network Provider, the member must pay the entire bill at the time the services are rendered. To request reimbursement for Covered Services EyeMed Vision will need the following information:

- The name, address and phone number of the Out-of-Network Provider along with an itemized statement of charges
- The covered Member's name and address, group number, Social Security number or Member identification number
- The patient's name, birthdate and relationship to the Member

The Member should keep a copy of the information and send the originals to the following address:

First American Administrators
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Time Frames for Appealing Claims

If your claim is denied, in whole or in part, you may appeal. The appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your appeal will be decided within 60 days after receipt. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the FAA denial information or Explanation of Benefits, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's appeal, such as documents, records, questions or comments.

You may authorize someone else to file and pursue a complaint or appeal on your behalf. If you do so, you must notify FAA/EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to pursue the complaint

and/or appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your appeal for benefits and notify you in writing of its decision.

Complaint Procedure
If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at ***1- 866-800-5457*** to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after EyeMed receives the claim or other request for benefits and within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure before filing a lawsuit or other legal action of any kind against the Plan. If your vision benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

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 866.895.5975. The plan website is: iuhealthplans.org.
- **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

Persons employed by Indiana University as full-time (75% FTE or greater) Academic or Staff employees are eligible for plan membership. Employees in positions less than full-time, including Temporary employees, are not eligible for plan membership.

In addition to the University's eligibility requirements for the IU Health HDHP medical plan, the IRS has other enrollment requirements to participate in the HSA portion of the plan and for the University and the member to make tax free HSA contributions.

Your Dependents eligible for enrollment include:

1. Legally married spouse (same or opposite sex).
2. Children* 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 Indiana University Employee Benefit Plan.)
3. 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 at the time of enrollment and determined to be qualified as set forth below.

*Children include natural or legally adopted children of the Covered Person or spouse, children placed for adoption, stepchild, and a child for whom the employee or spouse has been legally appointed sole guardian.

Coverage Options:

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

Eligibility Verification

New hires and existing Covered Persons enrolling themselves and/or Dependents in medical coverage must provide supporting documentation within 30 days of hire or life event change to IU Human Resources for verification of eligibility. Acceptable documentation is outlined below.

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.

- 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 30 days of hire or life event change to Human Resources for verification of eligibility for an enrolled Dependent for Plan coverage to become effective.

Contact IU Human Resources if you have any questions about the eligibility of any Dependents you would like to enroll for coverage.

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 within 30 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 may also enroll during this special enrollment period for newly acquired Dependents. Coverage for this Dependent will become effective on the date they become a dependent. If you wait longer than 30 days, the Dependent and/or you and your eligible spouse 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.

Claims for a newborn child of a covered employee will be covered immediately from birth for the first 31 days if the employee was covered under the Plan on the child's date of birth; and the newborn meets the definition of eligible dependent.

Giving notice to the Plan Administrator does not automatically add the newborn to the employee's medical plan. In order for the newborn to have coverage beyond the first 31 days, the employee must:

- Enroll for dependent coverage, or add the dependent to existing coverage by submitting the changes online in the Employee Center in One. IU within 30 days of the child's birth (even if the employee is currently enrolled in Family or Employee w/Child(ren) coverage); and
- Pay any contributions for the newborn child to continue as a covered dependent.

If the addition of the newborn child results in a higher contribution to the plan, the employee will be charged the higher contribution rate for the entire period of the child's coverage, including the first 31 days.

Health Benefit Enrollment Process

Newly Hired and Current Covered Persons

When you begin working at Indiana University, you are given an opportunity to enroll in Indiana University Employee Benefits Plan. **You must complete the online enrollment process within the first 30 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 held in the 4th quarter of each year.

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 30 days to complete a special enrollment from the date of the family status change. Life Event Changes can be made online through the Benefits section of the Employee Center in One.IU.

If you do not enroll within the 30-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 30 days of your start date, your coverage becomes effective on the first day of active employment as an eligible employee. In the event that the employee is placed on leave at the time of initial employment, then the employee's coverage will become effective on the first day of active employment as an eligible employee.

It takes approximately 15 business days from the time your information is received 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 IU Human Resources. Enrollment should be completed online. Remember to retain a copy of your information for reference.

Plan Premiums
All coverage is contributory. Contributions toward the cost of the benefits provided by this Plan will be deducted from the employee's pay and are subject to change. Employee contributions will be treated as salary deductions, and are made on a pre-tax basis. Enrollment in this Plan includes automatic coverage under the University's Tax Saver Benefit Plan Premium Conversion, and provisions for enrollment changes are subject to Internal Revenue Code Section 125.

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;

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 life 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 IU Human Resources. Adjustments to coverage must be consistent with the changes resulting from the qualifying life event and must be completed within 30 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 Indiana University 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 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 30-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 IU Human Resources.

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; 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

Indiana University 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.

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. See the University Leave of Absence Policy for details.

Approved Leave of Absence
If you are no longer Actively At Work, termination of coverage may be deferred while you are on an approved leave of absence. The required employee contribution must be paid during leave-of-absence periods. This coverage will cease if you fail to pay the monthly contribution, effective with the last contribution period.

Termination of Coverage

Healthcare coverage may terminate for several reasons. These include:

- Indiana University 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 under this Plan will terminate at the end of your contribution period when you no longer make the required contributions. Coverage may terminate sooner for Dependents if you die or get divorced. You may elect to extend coverage if Plan coverage is lost due to one of the COBRA-related provisions.

If you were covered by this plan at the time of termination and meet the qualifications for IU Retiree status, you may participate in an IU-Sponsored Retiree health care plan available at that time. Please contact IU Human Resource office to initiate such an enrollment.

You are responsible for notifying the University in writing within 30 days of any change that affects a covered Dependent's eligibility. An enrollee ceases to be a covered Dependent on the date the enrollee no longer meets the definition of a Dependent, regardless of when notice is given to the University. You are responsible for notifying the University in writing within 30 days to initiate any reduction in premium contribution. Failure to provide timely notice may result in employee liability for claims paid and/or university contributions made during the period the Dependent was ineligible.

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 the University with notice of the event along with an enrollment change request form to Human Resources within 30 days of the loss of other coverage or termination of company contribution. In such case, the Effective Date of coverage will be the date of the qualifying event.

[Note: If a properly completed enrollment form is not received within 30 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 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 IU Human Resources 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

IU Human Resources 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 -- IU Human Resources 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 iuhealthplans.org or by contacting IU Health Plans Member Services at 866.895.5975 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 iuhealthplans.org to access a claim form. Claims should be submitted to:

Indiana University Health Plans

PO Box 11196

Portland, ME 04104-7196

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 866.895.5975 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 Indiana University 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.

VehicleLimitation

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 every two years in January.

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 Indiana University 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 Indiana University 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, and with applicable laws. 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 for Network Providers, and three hundred sixty-five (365) days of the date charges for the service(s) and/or supplies were incurred for Non-Network Providers. 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 UB04:

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:

Indiana University Health Plans

PO Box 11196

Portland, ME 04104-7196

Fax: 812.314.2543
Phone: 866.895.5975

Pharmacy Grievance or Appeal:
Contact: CVS Caremark
Phone: 866-234-6952

Your initial response will addressed by a Customer Service Representative. Your concerns will be logged into CVS Caremark Customer Service Contact System. Unresolved complaints will be escalated to a customer service resolution expert or to a supervisor. You can also request that your issue be escalated. If your issue is still not resolved to your satisfaction, you have the right to file a formal appeal either verbally by phone or by mail. You will receive a follow up phone call and/or letter regarding resolution of your issue.

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 866.895.5975 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. 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.

F. Limitation of Action

A Covered Person cannot bring any legal action against the University 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 University 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 University or the ASO.

A Covered Person cannot bring any legal action against the University 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 University 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 University or the ASO.

Questions or Concerns

Contact IU Health Plans Member Services at 866.895.5975 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.

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.

Indiana University Health Affiliated Covered Entity
Notice of Privacy Practices
Effective date – Jan. 1, 2021

IU HEALTH AFFILIATED COVERED ENTITIES COVERED BY THIS NOTICE
This Notice of Privacy Practices describes the privacy practices of the healthcare providers and health plans participating in the Indiana University Health Affiliated Covered Entity (referred to herein as "IU Health ACE" and "IU Health"), including hospitals, physician practices, pharmacies, ambulatory surgery centers, health plans and other healthcare providers under Indiana University Health common ownership or control who have designated themselves as a single affiliated covered entity for purposes of compliance with the Health Insurance Portability and Accountability Act (HIPAA). Members of the IU Health ACE will share protected health information with each other as necessary to carry out treatment, payment and healthcare operations and as permitted by HIPAA and this Notice. A copy of the current list of the participant members of the IU Health ACE is available online at iuhealth.org or by requesting from the IU Health Privacy Office.

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IU Health is required by law to maintain the privacy of protected health information. IU Health believes your health information is personal and is committed to maintaining its confidentiality. This Notice describes our legal duties and privacy practices with respect to your protected health information.

"Protected health information" is your health information or other individually identifiable information, such as demographic data, that may identify you. Protected health information relates to your past, present or future physical or mental health or condition related to healthcare services. It also includes information about payment for healthcare you have received, including payment for medical services under health insurance plans and employer-sponsored health plans such as a healthcare flexible spending account (FSA) and/or a health reimbursement arrangement (HRA) plan.

This Notice of Privacy Practices describes how IU Health may use and disclose your protected health information to carry out treatment, for payment, for healthcare operations and for other purposes permitted or required by law. This Notice also describes certain rights that you have with regard to your protected health information. IU Health is required to abide by the terms of this Notice of Privacy Practices.

The terms of this Notice may change at any time. The new Notice will apply to all protected health information acquired about you. Upon your request, IU Health will provide you with any historical Notice of Privacy Practices or you may obtain the most current copy by visiting the IU Health website at iuhealth.org.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT DO NOT REQUIRE YOUR AUTHORIZATION

Your protected health information may be used and disclosed by IU Health, its staff and others outside of its offices who are involved in your care and treatment for the purpose of providing healthcare services to you. Your protected health information may also be used and disclosed to pay your healthcare bills and to support the operations of IU Health. The following list, by way of example rather than limitation, explains certain uses and disclosures of your protected health information that IU Health is permitted to make.

TREATMENT

IU Health will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with another provider. For example, IU Health may disclose your protected health information to a home health agency that provides care to you.

IU Health will also disclose health information to physicians or other healthcare providers who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, IU Health may disclose your protected health information from time to time to another physician or healthcare provider (e.g., specialist) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment. As another example, a doctor treating you for a broken leg may need to know if you have diabetes, because diabetes may slow the healing process.

PAYMENT

IU Health may use and disclose your protected health information as necessary so that we or other entities involved in your care may obtain payment from you, your health insurance plan or other third party for the healthcare services you receive. This may include providing your protected health information to your health insurance plan before it approves or pays for recommended healthcare services so that it may make a determination of eligibility or coverage for insurance benefits.

It may also include supplying the information to review services provided to you for medical necessity

and to undertake utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health insurance plan to obtain prior plan approval.

HEALTHCARE OPERATIONS

IU Health may use or disclose your protected health information for certain administrative, financial, legal and quality improvement activities that are necessary to run our business. These uses and disclosures are made to enhance quality of care and for medical staff activities, education and teaching programs, and general business activities. It also includes, but is not limited to, population-based activities for improving health, employee review activities, licensing, determining premiums for your health plan, and conducting or arranging for other business development activities. IU Health may share your protected health information with "business associates," or third-party organizations that perform services such as billing or transcription services on behalf of IU Health. IU Health has written contracts with our business associates to protect the privacy of your protected health information, and these business associates are required by law to comply with the same privacy and security requirements that apply to IU Health.

IU Health may use and disclose your protected health information to tell you about appointments and other matters related to your care, to respond to a customer service inquiry from you, to pay claims for services provided to you, to review provider performance, or in connection with fraud and abuse detection and compliance programs. We may contact you by mail, telephone, text or email. IU Health may leave voice messages at the telephone number you provide, and we may respond to your emails.

IU Health may use and disclose protected health information to tell you about possible treatment options, disease management programs, health-related benefits, new services or alternatives that may be relevant to your healthcare. For example, IU Health might send you information about our own programs to help you manage your asthma or diabetes, or our healthcare plans may inform health plan enrollees of health-related products or services available.

HEALTH INFORMATION EXCHANGE

IU Health may share information that we obtain or create about you with other healthcare providers or other healthcare entities, such as your health plan or health insurer, as permitted by law, through Health Information Exchanges (HIEs) in which we participate. For example, information about your past medical care and current medical conditions and medications can be available to us or to your non- IU Health primary care physician or hospital, if they participate in the HIE as well. Your hospital or healthcare provider may also participate
in HIEs, including HIEs that allow your provider to share your information directly through our electronic medical record system. You may choose to opt out of HIEs by contacting the Health Information Management department at IU Health.

HOSPITAL DIRECTORY

IU Health may include limited information about you in the hospital directory while you are a patient. This information may include your name, location in the hospital and your general condition (e.g., fair or stable). This directory information may be released to people who ask for you by name. If you do not want this information shared, please let IU Health know. Also, your religious affiliation may be given to a member of the clergy even if they do not ask for you by name.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE

Unless you indicate otherwise, IU Health may disclose to a relative, a close friend or any other person you identify, the portion of your protected health information which directly relates to that person's involvement in your healthcare or payment for your healthcare. If you are unable to agree or object to such a disclosure, IU Health may disclose such information as necessary for your healthcare or payment for your healthcare, if, based on our professional judgment,

IU Health determines that it is in your best interest. IU Health may disclose protected health information to notify or assist in notifying a family member or personal representative (or any other person who is responsible for your care) of your location, general condition or death.

Finally, IU Health may disclose your protected health information to an authorized public or private entity to assist in disaster-relief efforts.

GROUP HEALTH PLAN SPONSORS

IU Health may disclose your protected health information to a sponsor of a self-funded group health plan—such as an employer or other entity—that is providing a healthcare program to you, for plan administration purposes (e.g., claims management, appeal decisions, medical review). Additionally, if your company's group health plan contracts with IU Health to provide coverage for its employees, then we may provide your company with summary health information for premium billing purposes, modifying or terminating the plan, or to perform enrollment and disenrollment activities.

GENETIC INFORMATION

IU Health is prohibited from using or disclosing genetic information for health plan insurance coverage underwriting purposes and employment purposes. Underwriting involves whether our health plan gives you coverage and the price of the coverage.

RESEARCH

IU Health performs medical research to improve the health of individuals. All research projects conducted at IU Health must be approved through a special review process to protect patient safety, welfare and confidentiality. IU Health may use and disclose your protected health information for research purposes under specific rules determined by the confidentiality provisions of applicable law. In some instances, federal law allows us to use your medical information for research without your authorization, provided we get approval from a special review board. IU Health may release information about you to researchers who need to know how many patients have a specific health issue in preparation for proposed research. You may be contacted about research studies that may benefit you to see if you are interested in the study, provide you with more information and give you the opportunity to participate or to decline further contact.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY

IU Health may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of another person or the public. However, any disclosure would only be to someone who is able to help prevent the threat.

ORGAN AND TISSUE DONATION

IU Health may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ-donation bank as necessary to facilitate organ or tissue donation and transplantation.

WORKERS' COMPENSATION

IU Health may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

PUBLIC HEALTH RISKS AND PATIENT SAFETY ISSUES

IU Health may disclose protected health information about you for public health activities and purposes to a public health authority that is permitted by law to receive the information. For example, disclosures may be made for the purposes of preventing or controlling disease, injury or disability; to report births and deaths; to report reactions to medications or problems with products; and to notify people of recalls of products that they may be using.

COMMUNICABLE DISEASES

IU Health may disclose or use your protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and to comply with state-mandatory disease reporting, such as cancer registries.

ABUSE OR NEGLECT

IU Health may disclose your protected health information to a public health authority authorized by law to receive reports of child abuse or neglect, and to notify the appropriate government authority if IU Health believes a patient or health plan member has been the victim of abuse, neglect or domestic violence under certain circumstances. IU Health will only make this disclosure when required or authorized by law.

HEALTH OVERSIGHT ACTIVITIES

IU Health may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, the health insurance system, government benefit programs and compliance with civil rights laws.

FOOD AND DRUG ADMINISTRATION (FDA)

IU Health may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety or effectiveness of FDA-regulated products or activities, which include: to report adverse events, product defects or problems; biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct

post marketing surveillance, as required.

LEGAL PROCEEDINGS

IU Health may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) or, in certain conditions, in response to a subpoena, discovery request or other lawful process.

LAW ENFORCEMENT

IU Health may disclose protected health information for certain law-enforcement purposes as authorized or required by law, such as: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime, if under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at the location of an IU Health entity; and, when responding to a medical emergency off-campus or a location other than the IU Health entity, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

IU Health may release protected health information to a coroner or medical examiner, for example, to identify a deceased person or determine the cause of death. We may also release protected health information about patients of the hospital to funeral directors as necessary to carry out their duties.

MILITARY ACTIVITY AND NATIONAL SECURITY

IU Health may use or disclose the protected health information of individuals who are armed forces personnel for activities deemed necessary by appropriate military-command authorities when we are authorized by law to do so, including disclosures to foreign military authorities when permitted by law. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the president or others legally authorized.

INMATES

If you are an inmate of a correctional institution or under the custody of a law enforcement official, IU Health may release protected health information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with healthcare, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

REQUIRED BY LAW

IU Health may use or disclose your protected health information to the extent that such use or disclosure is permitted or required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT DO REQUIRE YOUR

AUTHORIZATION

As described above, IU Health will use your protected health information and disclose it outside of IU Health for treatment, payment, healthcare operations, and when permitted or required by law. Other uses and disclosures of your protected health information not covered by this Notice will be made only with your authorization. IU Health will not sell your protected health information nor disclose it to third parties for marketing purposes. In addition, certain disclosures of your psychotherapy notes, mental health records, and drug and alcohol abuse treatment records may require your prior written authorization. IU Health will protect substance-use disorder records in accordance with 42 CFR part 2 regulations, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and other implementing regulations, which is to include authority for use and disclosure, once a patient gives prior written consent, of the contents of substance use disorder records for purposes of future treatment, payment and healthcare operations as permitted by the HIPAA regulations, until such time as the patient revokes the consent.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

The records of your medical and claims information are the property of IU Health. You have the following rights, however, regarding protected health information we maintain about you:

RIGHT TO INSPECT AND COPY

You have the right to inspect and obtain an electronic or paper copy of your protected health information that may be used to make decisions about your care and benefits. This includes medical, billing and claims records, but does not include psychotherapy notes. To request a copy of your protected health information, contact the Health Information Management department at IU Health. If you request a copy of the information, IU Health may charge a reasonable fee. IU Health may deny your request to inspect and copy in some limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. A licensed healthcare professional chosen by IU Health will review your request and the denial. The person conducting the review will not be the person who denied your request. IU Health will comply with the outcome of the review.

RIGHT TO AMEND

You have a right to request an amendment of the protected health information that IU Health has in our records. Your request for an amendment must be made in writing, including a reason for the request, and submitted to the Health Information Management department at IU Health. If we accept your request, we will tell you we agree and will amend your records, which is generally by the addition of a supplemental addendum. With your assistance, we will notify others who have the incorrect or incomplete medical information. IU Health may deny a request for an amendment. If we deny your request, we will give you a written explanation of why we did not make the amendment and explain your rights. IU Health may deny an amendment request if it: is not in writing and does not include a reason to support the request for amendment; was not created by IU Health (provided, however, IU Health will still review amendment requests if the person or entity that created the medical information is no longer available to respond to your request); is not part of the designated record set kept by IU Health; is not part of the information which you would be permitted to inspect and copy; or is determined by us to be accurate and complete.

RIGHT TO RECEIVE NOTIFICATION

An individual will receive a notification if his or her unsecured protected health information is breached.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an accounting of disclosures we have made of your protected health information. This list will not include every disclosure made, including those disclosures made for treatment, payment, healthcare operations or disclosures you authorized in writing. To request an accounting of disclosures, include the specific time period desired and submit your request in writing to the Health Information Management department at IU Health.

IU Health will not list disclosures made earlier than six years before your request. The first accounting of disclosure to you in any 12-month period is free. Additional accounting of disclosures requested by the same individual within the 12-month period may cost a fee; you will be notified in advance of any cost involved so that you may choose to withdraw or modify your request before incurring a cost.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction on the ways your protected health information is used or disclosed to carry out treatment, payment or healthcare operations. To request a restriction, submit your request in writing to the Health Information Management department at IU Health. The request should include what information you want to limit, whether you want to limit use or disclosure, or both, and to whom you want the limits to apply—for example, disclosures to your spouse. IU Health is not required to agree to your request. If we do agree, we will comply with your restriction unless the information is needed to provide emergency medical treatment.

IU Health will agree to restrict disclosures of your health information to your health insurance plan for payment and healthcare operations purposes (not for treatment) if the disclosure pertains solely to a healthcare item or service for which you paid in full.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION

You have the right to request that IU Health communicate with you about healthcare matters in a certain way or at a certain location. For example, you can request that you are only contacted at work or at a specific address. Such requests should be made in writing to the Health Information Management department at IU Health and should specify how or where you wish to be contacted. IU Health will accommodate all reasonable requests.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may ask us to give you a copy of this Notice at any time. Copies of this Notice will be available throughout IU Health, or by contacting the Health Information Management department at IU Health. You may also find an electronic copy of this Notice on the IU Health website, iuhealth.org.

OTHER USES OF PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information not covered by this Notice or allowed by law will be made only with your written permission. If you provide permission to use or disclose protected health information, you may revoke that permission, in writing, at any time. If you revoke your permission, IU Health will no longer use or disclose protected health information about you for the reasons covered by your written authorization. IU Health is unable to take back any disclosures it may have already made with your permission.

USE OF UNSECURE ELECTRONIC COMMUNICATIONS

If you choose to communicate with us or any of your IU Health providers via unsecure electronic communication, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or account from which you sent your original communication. Before using any unsecure electronic communication to correspond with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others or messages stored on unsecured, portable electronic devices. By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that use of email is not intended to be a substitute for professional medical advice, diagnosis or treatment. Email communications should never be used in an emergency. We recommend that you use the patient portal for secure electronic communications with myiuhealth.org.

When you visit and use our websites or use certain of our online services, we may collect and share other digital data and personal information not covered by this Notice of Privacy Practices, including through the use of cookies and other similar website tracking technologies (such as, for example, your internet protocol address automatically assigned to your computer by your internet service provider, device operating system, device information, browser type and language, and referring URLs). This collection and sharing is governed by our IU Health website privacy policy and not this Notice. You should review the terms contained on our website privacy policy for detailed information on the type of cookies and other technologies we use, what information we collect, the reasons why we use these technologies, as well as the terms associated with using our websites and online services.

CHANGES TO THIS PRIVACY NOTICE

IU Health reserves the right to change this Notice and to make the revised or changed Notice effective for protected health information we already have about you, as well as any information we receive in the future. The revised Notice of Privacy Practices will be posted on the IU Health website at iuhealth.org or mailed to you. In addition, at any time you may request a copy of the Notice currently in effect.

QUESTIONS OR COMPLAINTS

If you believe IU Health has violated your privacy rights, you may file a complaint with us. Please send any complaint to the IU Health Privacy Office at the address, email or telephone number provided below. You may also file a complaint with the secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

If you have questions about this Notice of Privacy Practices, contact the IU Health Privacy Office at

317.963.1940 or hipaa@iuhealth.org.

NOTICE OF NONDISCRIMINATION

IU Health does not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, genetic information, veteran status, national origin, gender identity and/or expression, marital status, or any other characteristic protected by federal, state or local law.

ATTENTION: Language assistance services, free of charge, are available to you. Call 317.962.2142 (8 am – 4:30 pm) or 317.962.5500 (all other times).

CONTACT INFORMATION

Health Information Management Department at IU Health
DG 412
1701 N. Senate Blvd.
Indianapolis, IN 46202
T 317.962.8670
iuhealth.org/patients/medical-records

IU Health Privacy Office
Fairbanks Hall, Suite 3100
340 W. 10th St.
Indianapolis, IN 46202
T 317.963.1940
Email: hipaa@iuhealth.org

IU Health Foundation
Attn: Advancement Operations, Opt Out
Methodist Medical Tower
1633 N. Capitol Ave., Suite 1200
Indianapolis, IN 46202
T 317.962.1777
Email: foundationinfo@iuhealth.org

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
T 800.368.1019
TDD 800.537.7697
hhs.gov/ocr

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. 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 Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise an ASO to pay claims.
9. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
11. 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.

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.

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 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.

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

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.

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 Plan Document 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 Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, 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 extent 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 University's obligation with respect to such payments.

In the event that the University 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 University 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

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.

"**Actively At Work**" or "**Active Employment**" - The Employee who has begun and is performing all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another designated location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

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.

Air Ambulance – means medical transport for a patient by a rotary wing air ambulance or fixed wing.

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.

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.

Alternative Care Facility – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:

1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI).
2. Surgery.
3. Therapy Services or rehabilitation.

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:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an Outpatient basis;
2. Provides treatment to Covered Persons by or under the supervision of Physicians and nursing services;
3. Does not provide Inpatient accommodations; and
4. 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 Plan Document, 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 Plan Document. 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.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by IU Health Plans, on behalf of the Plan, to be paid at the Network level.

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:

1. It mainly provides an Outpatient setting for childbirth following a normally uncomplicated pregnancy, in a home-like atmosphere.
2. 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.
3. 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.
4. 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.
5. 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.
6. It schedules Confinements of not more than 24 hours for a birth.
7. It maintains medical records for each Covered Person.
8. It complies with all licensing and other legal requirements that apply.
9. 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.

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.

Continuing Care Patient – an Enrollee who, with respect to a Participating Provider meets any of the following criteria.

1. Is undergoing a course of treatment for a Serious and Complex Condition from the Participating Provider.
2. Is undergoing a course of institutional or inpatient care from the Participating Provider.
3. Is scheduled to undergo nonelective surgery from the Participating Provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.
4. Is pregnant and undergoing a course of treatment for the pregnancy from the Participating Provider.
5. Is or was determined to be terminally ill and is receiving treatment for such illness form the Participating Provider. For purposes of this subsection, an individual is considered to be terminally ill if the individual has a medical prognosis that the individual's life expectancy is 6 months or less.

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.

Diagnostic (Service/Testing) – A test or procedure performed on a Member, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a Member who is not displaying any symptoms. However, this must be ordered by a Provider. Examples of covered Diagnostic Services in the Covered Services section.

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 pregnant woman, the woman's 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 or Emergency – A medical condition, including a mental health condition or substance abuse disorder manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, 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 woman, the health of the woman or her 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 Care – with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the Emergency department of a Hospital or an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition and within the capability of the staff and facilities available at the Hospital or Independent Freestanding Emergency Department, and such further medical examination and treatment to stabilize the patient. The term "stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant person who is having contractions, the term "stabilize" also includes the delivery (including the placenta) if there is inadequate time to affect a safe transfer to another Hospital before delivery or a transfer may poste a threat to the health or safety of the pregnant person or the unborn Child.

Employee – A person directly involved in the regular business of and compensated for services by the Employer, who is full-time (75% FTE or greater).

Employer – The Employer is Indiana University.

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.

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 Freestanding Emergency Department – a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and provides any Emergency Services.

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 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 or First Health.

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. Alternative Facility;
3. A Physician's office, laboratory or x-ray Facility; or
4. An Ambulatory Surgical Facility

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 Health Care Facility – In the context of non-emergency services, means a hospital, or a critical access hospital (as such terms are defined in Section 1861 of the Social Security Act), a hospital outpatient department, or an ambulatory surgical center (as described in Sec. 1833 of the Social Security Act).

Participating Pharmacy – Any pharmacy licensed to dispense Prescription Drugs, which is contracted with the pharmacy program offered through the Plan.

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 Indiana University 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, Indiana University.

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 a woman 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 express-scripts.com.*

Prescription Quantity Limit – The maximum quantity of specified medications and medication strengths that can be dispensed over a defined days 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 women 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, general internist, gynecologist, or obstetrician.

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 – An individual who qualifies for continued coverage under the university's Retiree group life insurance plan upon termination of employment.

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.

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.

Serious and Complex Condition – In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness or condition, a condition that is

1. Life-threatening, degenerative, potentially disabling, or congenital; and
2. Requires specialized medical care over a prolonged period of time.

Service Area – The geographical area where the Plan's Covered Services are available, as approved by state regulatory agencies.

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.

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.

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").

Utilization Review – See Medical Management.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.