



INDIANA UNIVERSITY
UNIVERSITY HUMAN RESOURCE SERVICES

IU DENTAL PLAN

Full-time Academic and Staff Employees
Summary of Plan Provisions

Dental Coverage Administered by
Connecticut General Life Insurance Company (CGLIC)
“CIGNA”

JANUARY 2011

FOREWORD

This booklet describes the optional dental benefits provided by Indiana University. The dental benefits are administered by Connecticut General Life Insurance Company (CGLIC) using the CIGNA Dental PPO network.

Indiana University reserves the right to amend or terminate all or any part of this plan. If plan provisions are amended, participants will receive a summary of the amendment or a revised booklet reflecting any changes made in the principal features.

The benefits described are effective January 1, 2011.

Principal Features

The IU Dental Plan is an optional benefit plan. Eligible employees may elect dental coverage *with* or *without* electing medical coverage. Dependents who are enrolled in dental coverage may be different than those enrolled in medical coverage.

Members may receive dental care from any licensed dentist. However, members will receive a higher level of benefit when covered services are obtained from a CIGNA PPO Network dentist, since these dentists have agreed to accept a reduced, negotiated fee for their services.

The IU Dental Plan has an annual benefit limit of \$1,200 per covered member. Child orthodontia is covered up to a \$750 lifetime limit per participating child.

Members receive the following coverage according to the network status of the dentist used:

PPO Network Dentist

- Annual \$25 deductible (not applied to preventive care).
- Two routine cleanings/exams per year covered at 100%.
- Other services covered at 50%.

Non-network Dentist

- Annual \$25 deductible.
- Two routine cleanings/exams per year covered at 100% at Usual & Reasonable (U&R).
- Other services covered at 50% of U&R.
- Member responsible for amounts above U&R.

For more information visit:

hr.iu.edu/benefits/dental.html

Customer Service Information

Many customer service needs can be met by using the University Human Resource Services Web site:

hr.iu.edu

- Find a link to the CIGNA Provider Directory. Use this link to find participating PPO Network dentists (www.cigna.com);
- Obtain a copy of the CIGNA Dental Claim form. Use this form to submit claims for reimbursement in cases where the dentist does not submit claims for the member;
- Obtain the CIGNA customer service phone number. Call this phone number to check on claim status;
- Find a link to print a copy of the Dental PPO ID card;
- View or print a copy of the IU Dental Plan Summary or this IU Dental Plan booklet.

If Internet access is not available:

- Contact CIGNA Dental Member Services for the following services:
 - Checking claim status;
 - Finding a network dentist or obtaining a copy of a Network Dentist Directory.
- Contact the campus Human Resources office for the following services:
 - Obtain a copy of the *CIGNA Dental Claim* form;
 - Obtain a Dental PPO ID card (cards are not personalized with the member's name);
 - Obtain an IU Dental Plan summary or booklet.
 - Name change;
 - Changes in status.

CIGNA Dental PPO Member Services Phone Number:

1-800-CIGNA-24 (or 1-800-244-6224)

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Effective January 1, 2011

Material in this booklet is for informational purposes only and is not intended to serve as a legal interpretation of benefits. All coverage information is intended only to describe benefits provided by this plan, and is not intended to limit or exclude services that members may elect.

IU Dental Plan Distinguishing Features

The IU Dental Plan provides PPO benefits with the CIGNA network dentists. The plan pays benefits when members receive covered services from any licensed dentist; however, a higher level of benefit is paid when a PPO network dentist is used. PPO network dentists can be identified at the CIGNA Web site at www.cigna.com.

	When you use a PPO Network Dentist	When you use an Out-of-Network Dentist
Maximum Covered Charges	Billed charges up to negotiated fee schedule. No “balance billing”* other than the applicable deductible and copays.	Billed charges up to Usual & Reasonable (U&R). Member is responsible for any “balance billing”* by the dentist.
Annual Benefit Limit per Calendar Year	\$1,200 per member (combined In- and Out-of-Network)	\$1,200 per member (combined In- and Out-of-Network)
Annual Deductible	\$25 per member. (Does not apply to preventive)	\$25 per member.
Diagnosis/ Preventive Services	Two routine cleanings/exams per calendar year at 100% (not subject to deductible)	Two routine cleanings/exams per calendar year at 100% of U&R (subject to deductible)
Basic and Major Dental Services (such as fillings, crowns, dentures, implants)	50% of covered charges (subject to deductible)	50% of covered charges (subject to deductible)
Orthodontics	Child Orthodontia covered at 50% up to \$750 lifetime limit (subject to deductible)	Child Orthodontia covered at 50% up to \$750 lifetime limit (subject to deductible)
Exclusions/ Limitations	Some services are not covered, for example: cosmetic services and any services not listed as a covered benefit in the Plan Description. Other services may be limited by age or frequency; for example, cleanings. See plan booklet for full details.	

* Balance billing refers to charging for amounts above the maximum covered charge. (For example, billing patients for amounts above Usual & Reasonable (U&R) charges or a negotiated fee schedule.)

Eligible employees are able to elect dental coverage with or without electing medical coverage. This also means that eligible dependents that are not enrolled in medical coverage may be enrolled in dental as long as the employee is enrolled. If dental benefits are not elected at the time of initial eligibility, enrollment may not occur until the Open Enrollment period of the following year.

Section A — General Provisions

ELIGIBILITY FOR PLAN MEMBERSHIP

Eligible Employees

Persons employed by Indiana University as full-time appointed Staff or Academic employees are eligible for plan membership.

Effective Date of Coverage

Coverage becomes effective on the first day of active employment as an eligible employee, if the employee has enrolled within 30 days of such employment. (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.)

Coverage for midyear addition of newly eligible dependents is effective as of the date of the *Change in Status* that makes the dependent eligible but only if the written request is received within 30 days of the event. (See page 4 for information regarding Enrollment.) After 30 days of the date a dependent becomes eligible, the dependent cannot be added until the next Open Enrollment period, with an effective date of the following January 1. Changes of Status can be made online at the Benefits Change Connection at www.hr.iu.edu/bcc.

Eligible Dependents

Indiana University intends that all covered Dependents meet the criteria of such as defined by the IRS for excluding university contributions and the value of Covered Services from the employee's gross income.

Registered Domestic Partners are eligible; however, IRS regulations require that the value of their coverage is added to the employee's taxable income, unless the individual is a qualified tax Dependent of the employee. The IRS does not recognize the employee's Domestic Partner and/or children for preferential tax treatment. Domestic Partners and their tax-exempt children are eligible for IU-sponsored coverage, but the value of benefits provided to these individuals is added to the employee's taxable income, unless they can also be claimed as a tax exemption by the employee.

Dependents that are eligible for dental coverage are:

- The employee's spouse as defined by Indiana law; registered same-sex Domestic Partner; and
- Children who meet all of the following criteria:
 1. The child has one of the following relationships to the employee, spouse, or registered same-sex Domestic Partner:
 - A biological child; or
 - A lawfully adopted child; or
 - A stepchild of the employee; or
 - A child for whom the employee or spouse has been legally appointed sole guardian for an indefinite period of time; and

2. The child is age 25 or under (eligibility ends at the end of the month in which the child reaches age 26), or qualifies for Disabled Child Eligibility.
- An otherwise eligible child for whom the employee is legally required to provide health care coverage under a *Qualified Medical Support Order* as defined by ERISA.
 - When an adoption is in the legal process, coverage for such child may begin from the point the child is placed with the employee (granted custody) for the purpose of adoption.

No individual may be eligible for benefits as both an employee and as a Dependent or as a Dependent of more than one employee. A Dependent cannot become covered unless the employee is covered. All Dependents of covered employees are third-party beneficiaries of this Plan.

Proof that an individual is a qualified Dependent (marriage certificate, birth certificate, or guardianship orders as applicable) is required at the time of initial enrollment and periodically thereafter. Failure to provide proof of Dependent eligibility within 30 days of the University's written request for such proof may result in termination of health Plan coverage.

Employee contributions are associated with the coverage of eligible Dependents. Failure of an employee to make respective contributions will result in the discontinuation of Dependent coverage.

Disabled Child Eligibility

If the employee has a Dependent child who is covered under an IU-sponsored health care Plan, the child's medical coverage under the Plan may be continued beyond the maximum age for coverage as long as:

1. The child continues to have an eligible relationship to the employee as described in the Eligible Dependents section of this Benefit Booklet;
2. The child is covered under an IU-sponsored health care Plan at the time of reaching the maximum age for Dependent child coverage;
3. The employee continues to be covered;
4. The employee continues to maintain Dependent coverage under the plan; and
5. The Dependent child meets both of the following criteria:
 - a. The child is financially dependent on the employee, as evidenced by:
 - The child being claimed by the employee or the employee's spouse as an IRS tax exemption; and
 - The child not having resources (for example, trust fund or settlement) that would sustain the child financially; and
 - b. Due to physical or mental disability, the child is incapable of engaging in self-sustaining employment as evidenced by:
 - A physician's statement of the diagnosis, prognosis, and specific resulting symptoms that prevent the individual from being gainfully employed; and
 - The child not being enrolled in regular post-secondary educational classes on a part-time or full-time basis.

Proof that the child is fully disabled must be submitted in writing no later than 30 days prior to the date that Dependent coverage would have ceased. Indiana University has the right to require, at reasonable intervals,

proof that the child remains fully disabled, is Dependent on the employee for financial support, and otherwise satisfies the IRS criteria as a Dependent for the purpose of excluding university contributions and the value of Covered Services from the employee's gross income.

Domestic Partner Eligibility

IU-sponsored benefits are extended to same-sex Domestic Partners of Indiana University employees and associated children. In order to be eligible for IU-sponsored dental care plan enrollment, the individual must meet IU's criteria for a Domestic Partner and be registered by the employee with the University by submitting a notarized Affidavit of Domestic Partnership and supporting documentation as required by the Affidavit.

Children (biological, adopted, or qualified legal wards) of a qualified same-sex Domestic Partner are eligible if they meet the same eligibility requirements as children of the employee or employee's spouse with regard to age and/or disabled child eligibility.

Newborn Coverage and Enrollment

The newborn child of a covered employee will be covered immediately from birth for the first 31 days if:

1. The employee was covered under the plan on the child's date of birth; and
2. The newborn meets the definition of eligible dependent.

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

1. Enroll for dependent coverage, or add the dependent to existing coverage by submitting applicable forms to a Human Resources office within 30 days of the child's birth (even if the employee is currently enrolled in Family or Employee w/Child(ren) coverage); and
2. 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.

ENROLLMENT

To enroll in coverage, an employee must complete an enrollment form (online or paper) within 30 days from the first date of active employment, or within 30 days of the date the employee first becomes eligible for coverage, or during the Open Enrollment period of each year. If an employee does not enroll within 30 days of becoming eligible for coverage, the employee cannot enroll until the next Open Enrollment period.

An employee may change or drop plan coverage only during the annual Open Enrollment period, except as noted in the next section, Midyear Changes in Enrollment. Any enrollments or changes made during Open Enrollment become effective on January 1 of the next year and cannot be changed until the next Open Enrollment period. If an enrolled employee does not positively elect changes to their Medical and/or Dental Plan coverages during Open Enrollment, the present election will continue at the next year's contribution rate. 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.

Midyear Changes in Enrollment

If an employee experiences an IRS-qualified change of status event, the employee may make a corresponding revision to health care coverage as of the date of the event. Employees must provide the University with notice of the event within 30 days along with an enrollment change request. A *change of status* includes (as defined by federal regulations):

- Changes in legal marital status including marriage, death of spouse, divorce, legal separation, or annulment;
- Changes in number of Dependents (as defined in Code section 152) including birth, adoption, placement for adoption (as defined in regulations under Code section 9801), or death;
- Changes in employment status by the employee or the employee's spouse including termination or commencement of employment, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that causes the individual to become eligible or ineligible for coverage (such as an increase or reduction in hours or moving between salaried and hourly status);
- A Dependent satisfying or ceasing to satisfy the requirements for coverage due to attainment of age or similar circumstances;
- A change in the place of residence of the employee, the employee's spouse, or a Dependent child that affects eligibility for coverage;
- Special Enrollment in a health plan pursuant to HIPAA;
- Adding coverage for a child (child must meet IU eligibility requirements) if the employee is required to provide health coverage for a child under a court order, or removing coverage for a child if a court order requires the other parent to provide coverage and that parent actually does provide coverage;
- Any other event determined by the Internal Revenue Service (IRS) to be a qualifying event.

Medicaid/CHIP Special Enrollment Rights

The Children's Health Insurance Program (CHIP, formerly known as the State Children's Health Insurance Program or SCHIP) is a federal/state program designed to provide health care coverage for uninsured children and some adults.

Effective April 1, 2009, HIPAA Special Enrollment events were expanded to include a change in Medicaid/CHIP coverage. Generally, when Medicaid/CHIP coverage begins, IU-sponsored coverage can be terminated; when Medicaid/CHIP coverage ends, IU-sponsored coverage can be added.

To take advantage of this mid-year Special Enrollment right, individuals must:

- be otherwise eligible for IU-sponsored coverage; and
- experience a Medicaid/CHIP coverage change event; and
- provide the University with notice of the event within 60 days along with an enrollment request.

Changes in enrollment can be requested online through the Benefits Change Connection at www.hr.iu.edu/bcc.

A change in enrollment due to one of the above changes of status is allowed only if:

1. The employee, employee's spouse or Dependent gains or loses eligibility for coverage under this Plan or the health plan of the spouse or Dependent child; and
2. The change in enrollment in this Plan corresponds with that gain or loss of coverage.

The following Special Enrollment opportunities are available outside of the Open Enrollment period for eligible employees or Dependents that lose other employer group coverage for the following reasons:

- Loss of coverage due to the exhaustion of COBRA eligibility; or
- Loss of eligibility, termination of employer contributions, or termination of a plan altogether.

For employees that are eligible for IU-sponsored health coverage, 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.

Employees or Dependents who are already enrolled in Medicaid or CHIP, can contact their State Medicaid or CHIP office to find out if premium assistance is available.

Employees or Dependents who are NOT currently enrolled in Medicaid or CHIP, and who think they or their Dependents might be eligible for either of these programs, may can contact their State Medicaid or CHIP office or dial 1-877-KIDS NOW or visit www.insurekidsnow.gov to find out how to apply. Those who qualify, can ask the State if it has a program that might help pay the premiums for an Employer-sponsored plan.

Once it is determined that an employee or Dependent is eligible for premium assistance under Medicaid or CHIP, the Employer is required to permit enrollment in one of its health plans – as long as the individuals are eligible, but not already enrolled, in the Employer's plan. This is called a "Special Enrollment" opportunity, and coverage must be requested within 60 days of being determined eligible for premium assistance.

COORDINATION OF BENEFITS (COB)

This section applies if the employee or an eligible dependent is covered under more than one plan and determines how benefits payable from all such plans will be coordinated. Claims should be filed with each plan.

The IU Dental Plan Uses CIGNA's Standard COB Method. In general terms, under Standard COB, 100% of the total allowable expense is considered and claims are coordinated so that the insured may receive a maximum of 100% of Allowable Expenses.

The secondary plan determines its normal liability and pays the lesser of (a) the allowable expenses minus the primary plan's payment or (b) its normal liability.

COB Definitions

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the

meanings as specified in the below. In the rest of the Benefit Booklet, Plan has the meaning listed in the Definitions section. For the purposes of this section, the following terms have the meanings set forth below:

Plan - Any of the following that provides benefits or services for medical or dental care or treatment:

- (1) Group insurance and/or group-type coverage, whether insured or self-insured, which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- (2) Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- (3) Medical benefits coverage of group, group-type, and individual automobile contracts. Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan.

Closed Panel Plan - A plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan - The plan that determines and provides or pays benefits without taking into consideration the existence of any other plan.

Secondary Plan - A plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the reasonable cash value of any services it provided to you.

Allowable Expense - A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any plan covering you. When a plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit. Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- (1) An expense or service or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense.
- (2) If you are confined to a private hospital room and no plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- (3) If you are covered by two or more plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- (4) If you are covered by one plan that provides services or supplies on the basis of reasonable and customary fees and one plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- (5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period - A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value - An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A plan that does not have a coordination of benefits rule consistent with this section shall always be the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- (1) The plan that covers you as an enrollee or an employee shall be the Primary Plan, and the plan that covers you as a dependent shall be the Secondary Plan;
- (2) If you are a dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- (3) If you are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
 - (a) First, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage, and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - (b) then, the plan of the parent with custody of the child;
 - (c) then, the plan of the spouse of the parent with custody of the child;
 - (d) then, the plan of the parent not having custody of the child, and
 - (e) finally, the plan of the spouse of the parent not having custody of the child.
- (4) The plan that covers you as an active employee (or as that employee's dependent) shall be the Primary Plan, and the plan that covers you as laid-off or retired employee (or as that employee's dependent) shall be the Secondary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (5) The plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan, and the plan that covers you as an active employee or retiree (or as that employee's dependent) shall be the Primary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (6) If one of the plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the plan that has covered you for the longer period

of time shall be primary.

Effect on the Benefits of this Plan

If this plan is the Secondary Plan, this plan may reduce benefits so that the total benefits paid by all plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses. As each claim is submitted, the Plan Administrator will determine the following:

- (1) the plan's obligation to provide services and supplies under this policy; and
- (2) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

Recovery of Excess Benefits

If the plan pays charges for benefits that should have been paid by the Primary Plan, or if the plan pays charges in excess of those it is obligated to provide under the Policy, the plan will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

The plan will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

The plan, without consent or notice to you, may obtain information from and release information to any other plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Right of Recovery

If the Plan Administrator makes any payment for any covered person, including spouses and dependent children, that according to the terms of the plan should not have been made, including payment made in error, the Plan Administrator may recover that incorrect payment, whether or not it was due to error from the provider of service, or from any other appropriate party. If the incorrect payment is made directly to the member, the Plan Administrator may deduct it when making future payments directly to the member. The Plan Administrator may also recover an incorrect payment by reducing the payment for covered services to a provider.

TERMINATION OF COVERAGE

Coverage under this Plan will terminate when

- Employment terminates; or
- The employee ceases to be a Member of the eligible class for coverage; or
- The plan discontinues as a whole.

Coverage under this Plan will terminate at the end of the employee's contribution period when the employee fails to make required contributions.

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

Duty to Notify of Ineligibility

The employee is 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. The employee is 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.

Dependent Coverage

A Dependent's coverage will terminate on the earliest of the following dates:

- Upon discontinuance of all Dependents' coverage under the plan;
- When the employee ceases to be in the eligible class;
- When a Dependent becomes eligible for coverage as an IU employee;
- When such person ceases to meet the definition of Dependent; or
- When the employee coverage terminates.

A child of the employee or employee's spouse or registered same-sex domestic partner, may continue to be eligible to the end of the month in which the child attains age 26. Proof that the child is a qualified Dependent may be required at the time of initial enrollment and periodically thereafter.

Leave Without Pay

Commencement of, or return from a Leave Without Pay is an IRS-defined Change-in-Status event that allows an employee to drop and then resume IU-sponsored dental care coverage. Requests to make such changes must be made in writing within 30 days of the Change in Status.

If the employee does not request a change in participation in the IU Dental Plan at the commencement of an

unpaid leave, the employee is responsible for making arrangements to pay the employee contributions during the unpaid leave of absence. Failure to make contributions will result in termination of participation in the plan. Upon return from the unpaid leave, the employee may make a request to reinstate coverage so long as the request is made in writing within 30 days of the date of return from leave.

When terminating and resuming participation in an IU-sponsored dental plan in the same year, the employee must resume the dental plan election that was in place at the time that participation was terminated (IRS provision for preferential tax treatment of all contributions).

Release of Medical Records and Information

In order to administer the benefits described in this plan booklet, personal health information is exchanged between plan members, their health care providers, the Plan Administrator, and, in some cases, the Plan Sponsor. The types of uses of health information are described below. Indiana University has a longstanding policy of maintaining the confidentiality of such health information. Beginning April 14, 2003, the university, as the health Plan Sponsor, was also required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to protect the confidentiality of private health information. A complete description of employee rights under HIPAA can be found in the plan's Notice of Privacy Practices that is available to plan participants in a variety of ways: at the University Human Resource Services Web site; from the Health Care Data Administrator; the Notice of Privacy Practices in this booklet; and distribution to plan participants upon enrollment.

With respect to Protected Health Information (PHI), Indiana University, as Plan Sponsor:

- Will not use or disclose information other than as described by the plan documents or as required by law;
- Will ensure that anyone who receives information in the course of operating the health plan agrees to the same conditions that apply to the Plan Sponsor with respect to such information;
- Will ensure reasonable separation between the health plan and the Plan Sponsor such that health information is not used for employment-related actions and decisions, nor disclosed in connection with any other employee benefit plan without authorization;
- Will report to the plan's designee any use of information that it becomes aware is inconsistent with permitted uses;
- Will make such information available to an individual for review or amendment and provide an accounting of disclosures as required by HIPAA;
- Will cooperate with the Secretary of the U.S. Department of Health and Human Services as needed to determine the plan's compliance with HIPAA; and
- Will, if feasible, return or destroy all PHI received from the health plan when no longer needed; and if not feasible, limit further uses and disclosures consistent with HIPAA.

Within the university, only employees designated as having responsibility for benefit administration functions within Human Resources offices will be given access to HIPAA PHI. These individuals may only obtain and use PHI to carry out administrative functions needed to support the benefit plan. If these persons do not comply with the university's privacy practices, the university provides a procedure for resolving issues of noncompliance, including corrective sanctions.

Under HIPAA, a health plan member has certain rights with respect to PHI, including certain rights to see

and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. Members also have the right to file a complaint with the university or with the Secretary of the U.S. Department of Health and Human Services if there is a concern that rights have been violated.

How Your Health Information May Be Used by This Plan. The university, as the Plan Sponsor, engages various entities to administer these benefits on behalf of the plan, including third-party administrators, insurers, re-insurers, brokers, agents, or other entities providing services on behalf of the Plan Sponsor, Indiana University. The plan uses and discloses information for the purposes of treatment, payment, and to carry out plan operations. This includes such activities as processing applications for enrollment; customer service; underwriting; detecting and preventing fraud or misrepresentations; internal and external audits; administration of claims; appeal and grievance review; care management; quality improvement programs, reviews, and audits; peer review and credentialing; health care research; public health reporting; utilization review; coordination of benefits; subrogation; health promotion; and disease management and prevention. The health plan also uses and discloses personal health information as required by law and government oversight agencies.

The dental plan does not use personal health information for purposes other than HIPAA permitted uses without the written authorization of the member.

Dental plan administrators mail claim payment explanations for the employee, spouse, and children (adult and minor) to the address of record for the person in whose name the coverage is held, the employee. The dental plan also discloses information about the payment of claims by the plan for the spouse and children covered upon inquiry by the person in whose name the coverage is held. If the spouse and/or dependent child over age 18 does not want such information disclosed in this manner, or wishes to have the plan communicate with them in a different manner, the spouse or child must make a written request to the Plan Administrator stating where and how communication should take place. The Plan Administrator will make every effort to honor reasonable requests for special communications. A member, who has a question about the privacy of health information or wishes to file a complaint, may contact the Health Care Data Administrator in University Human Resource Services, 400 E. Seventh St., Poplars E165, Bloomington, IN, 47405-3085.

CONTINUATION OF COVERAGE (COBRA)

This is an important notice that the employee and dependents should read. Under federal law, employees have the right to continue healthcare coverage under COBRA, and in the case of termination for reason of military service, under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Federal law requires that the university offer employees and their covered dependents the opportunity for a temporary extension of medical coverage (called continuation coverage) at group rates in certain instances where coverage under the plan would otherwise end. Continuation of coverage under these provisions is generally 18 months to 36 months, depending on the circumstances. A detailed description of these COBRA provisions will be provided to each new employee with their orientation information and also at the time the university is notified that the employee has terminated and ceases dental coverage, or an eligible dependent otherwise becomes qualified for COBRA benefits. A copy of these COBRA provisions may be obtained at any time through a campus Human Resources office.

When the university is notified that an employee has experienced an event that qualifies him or her for continuation coverage, Indiana University will notify the participant of his or her right to choose continuation

coverage. Under COBRA, the participant has at least 60 days from the date the participant would lose coverage to inform Indiana University that he or she wants to continue coverage. If the participant does not choose COBRA continuation coverage, benefits under this plan will end and dental benefits cannot be added back at a later time.

SUBROGATION - REIMBURSEMENT

If a member is injured or becomes ill due to the actions caused by a third party, the Plan Sponsor may advance benefits for covered services for such illness or injury. Acceptance of such services will constitute consent to the provisions of this section.

In the event of any advanced benefits to a member, the Plan Administrator, on behalf of the Plan Sponsor, has the right of subrogation to recover the total amount of benefits the plan has paid on those charges. The Plan Administrator, on behalf of the Plan Sponsor, will have the right of first priority in any recovery. The plan is subrogated to any right the member may have to recovery from another, his or her insurer, or under any uninsured motorist, underinsured motorist, medical payment, no-fault, or other similar coverage provisions.

The Plan Administrator, on behalf of the Plan Sponsor, may take whatever legal action it sees fit against the third party to recover the advanced benefits paid under this plan. This will not affect the member's right to pursue other forms of recovery, unless the member or his or her legal representative consents otherwise.

The plan also has the right to be reimbursed from any recovery the member obtains from any party or through any coverage named above, regardless of how the member or the member's legal representative characterizes the recovery. The plan shall have a lien, in first priority, against any such recovery, in the amount of the payments it has made, and the member must hold the proceeds of the recovery in trust for the plan. The Plan Administrator, on behalf of the Plan Sponsor, may give such notice of such lien to the third party or insurance carrier. The Plan Administrator, on behalf of the Plan Sponsor, shall be entitled to deduct the amount of the lien from any future claims payable to the member if:

1. The lien is not repaid or otherwise recovered by the Plan Administrator; or
2. The member fails to notify the Plan Administrator of the payment received from the third party or insurance carrier.

The plan is entitled to reimbursement from any recovery, in first priority, even if it does not fully satisfy the judgment, settlement, or underlying claim for damages, or fully compensate the member. If the member is not fully compensated, the Plan Administrator will be reimbursed on a pro-rata basis.

The member shall advise the Plan Administrator, on behalf of the Plan Sponsor, of a claim or suit against a third party or insurance carrier within 60 days of the action. The Plan Administrator has the right to the member's full cooperation and shall provide the Plan Administrator any information requested by the Plan Administrator within five days of the request. The member is obligated to provide the Plan Administrator with whatever information, assistance, and records it may require to enforce its rights under this provision including, but not limited to, written notice to the Plan Administrator of any personal injury claim or any other claim for reimbursement for medical expenses filed with any person or business entity. The member shall not settle or compromise any claim unless the Plan Administrator is notified in writing at least 30 days before such settlement or compromise and the Plan Sponsor agrees to it in writing. The Plan Sponsor in its sole discretion may elect not to enforce this subrogation/reimbursement provision.

Section B — Dental Benefits

The IU Dental Plan is a Preferred Provider Organization (PPO) plan. Participants will receive benefits for covered services received from any licensed dentist. However, the member has lower out-of-pocket costs when the member uses dentists in the CIGNA dental PPO network. CIGNA PPO dentists have agreed to accept negotiated fees for covered services and do not “balance bill” members for amounts above Usual & Reasonable (U&R) allowed charges. Non-network dentists may bill members for amounts above U&R allowed charges.

Deductible

This plan option includes a \$25 deductible, per member, per year. The deductible applies to all covered services, except In-Network Type I (Diagnostic and Preventive) services.

Annual Maximum Benefit

The maximum amount payable for all covered services (except orthodontia), both In- and Out-of-Network, is \$1,200 per member, per calendar year.

Covered Charges

In-Network Benefits — CIGNA PPO contracted dentists have agreed to accept a specified fee schedule as their covered charge.

Out-of-Network Benefits — The covered amount for all dental benefits is limited to the Usual & Reasonable (U&R) reimbursement. The member is responsible for amounts above U&R.

Limit on Frequency

The frequency of certain covered procedures, such as cleanings, is limited. There may also be age limits on certain procedures. Such limits are listed in the PPO Services Schedule.

Predetermination of Benefits

Predetermination of benefits is a review by the Plan Administrator of a dentist’s description of planned treatment and expected charges, including those for diagnostic x-rays. **This review should be done whenever extensive dental work is proposed.** The information should be sent to the Plan Administrator *before the dental work is started*. If there is a major change in the treatment plan, a revised plan should be submitted.

When there has not been a predetermination of benefits, the Plan Administrator will determine the expenses that will be included as benefits payable at the time the claim is received.

Predetermination of benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a member qualifies at the time services are completed.

DENTAL SERVICES SCHEDULE

Type I Services: Diagnostic and Preventive

Benefits Paid — 100% of covered charges (subject to deductible for Non-Network DPPO dentists)

1. Routine clinical oral examinations — combined In- and Out-of-Network benefit limit of up to two exams per member, per year.
2. Routine oral prophylaxis (cleaning and scaling) — combined In- and Out-of-Network benefit limit of up to two cleanings per member, per year.
3. Topical fluoride application (excluding prophylaxis) — combined In- and Out-of-Network benefit limit of up to two applications per year for covered dependent children under age 19.
4. Emergency palliative treatment — palliative treatment of dental pain or minor procedures when no other definitive dental services are performed. (Any x-ray taken in connection with such treatment is a separate dental service.)
5. Space maintainers for covered dependent children under age 19 for non-orthodontic treatment.
6. Topical sealant application on a posterior permanent tooth. Limit: one treatment per tooth in any three calendar years.
7. X-rays, complete series — only one per member, including panoramic film, in any three calendar years.
8. Bitewing x-rays — only two charges per member, per calendar year.
9. Panoramic x-ray — only one per member in any three calendar years.
10. Periodontal maintenance procedures (cleaning following active periodontal therapy).

Type II Services: Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

Benefits Paid — 50% of covered charges

1. Restorations (fillings) of silver amalgam or composite/resin.
2. Extractions and other oral surgery, excluding procedures covered under medical benefits.
3. Local anesthetic, analgesic and routine post-operative care for restorative procedures, extractions and other oral surgery are part of the allowance for each covered dental service.
4. Administration of general anesthesia and IV sedation — paid as a separate procedure during oral surgery when medically or dentally necessary, as determined by the Plan Administrator, and when administered in conjunction with complex oral surgical procedures that are covered under the plan.
5. Periodontal scaling and root planing treatment of gum diseases.
6. Osseous surgery is covered; however, certain procedures or aspects of osseous surgery are not covered

as a separate procedure, as determined by the Plan Administrator. A predetermination of benefits is recommended in order to obtain benefit coverage information before the procedures are rendered.

7. Prosthodontic maintenance:

- Repair or recommendation of crowns or bridges.
- Repair or adjustment to dentures (adjustment or repair of a denture within six months of its placement is not a separate dental service).
- Relining or rebasing of dentures, one service per 12-month period. The denture must be at least 12 months old.

8. Endodontic treatment (treatment of pulp infections and root canal therapy) is covered; however, any x-ray, test, laboratory exam, or follow-up care is part of the allowance for root canal therapy and not a separate dental service.

Type III Services: Major Restorations, Dentures and Bridgework

Benefits Paid — 50% of covered charges

1. High noble metal (gold) or crown restorations are covered dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
2. Initial installation of crowns and fixed bridgework (porcelain, porcelain fused to high noble metal, full or three-quarter cast metal).
3. Fixed or removable full or partial dentures.
4. Replacement of a denture or bridge, if the appliance is at least five years old and cannot be made serviceable.
5. Replacement or addition of teeth to existing dentures or bridge, if required to replace teeth extracted after the appliance was installed.
6. The surgical placement of a dental implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Dental implant removal is covered only if the implant is not serviceable and cannot be repaired.

Type IV Services: Orthodontia Services

Benefits Paid — 50% of covered charges for orthodontia services for covered dependent children up to a \$750 lifetime benefit maximum per dependent child. This maximum applies across both In-Network and Out-of-Network PPO options.

1. Covered services — orthodontic work-up including x-rays, diagnostic casts, treatment plan, and the first month of active treatment, active treatment by the month after the first month (each month of active treatment is covered as a separate dental service), and retention appliances.

All orthodontia benefits will cease, including work in progress, when the member reaches age 19. Orthodontia in progress (orthodontia already started when coverage under this dental option begins) is not covered.

Section C — Exclusions

The IU Dental Plan provides no benefits for:

- Services in excess of the frequency of covered services as stated in the Dental Services Schedule.
- An appliance, or modification of one, if an impression was made before the member was covered under this plan; a crown, bridge, or gold restoration, for which the tooth was prepared before the member was covered under this plan; or root canal therapy if the pulp chamber was opened before the member was covered under this plan.
- Treatment or appliances for “harmful habits” such as bruxism (grinding teeth) or thumb sucking.
- Dental examinations, treatment, or processes, except as specifically stated as covered in this booklet.
- Procedures, appliances, or restorations (except full dentures) whose main purpose is to (a) change vertical dimension, (b) diagnose or treat conditions or dysfunction of the temporomandibular joint, (c) stabilize periodontally involved teeth, or (d) restore occlusion.
- Replacement or modification of a crown, gold restoration, denture, fixed bridge, or addition of teeth to a denture or bridge, if the initial installation was performed less than five years before the current service unless (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth, or (b) the bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.
- Services and supplies for replacing lost, missing, or stolen dental prosthetic devices.
- Services and supplies for replacement or repair of an orthodontic appliance.
- Any replacement of a bridge, crown, or denture which is, or can be, made useable according to common dental standards.
- Temporary dentures and temporary bridges.
- Personal hygiene and convenience items, such as electric toothbrushes or water picks, even if such items are prescribed by a dentist or physician.
- Bite registrations; precision or semiprecious attachments or splinting.
- Instructions for plaque control, oral hygiene, and diet.
- Expenses incurred before the member's coverage begins or after it ends, except as specifically stated as covered in this booklet.
- Injury or illness which resulted from being engaged in an illegal/criminal activity, including injury or illness resulting from intentional self-infliction.
- Services of a provider who is in the member's immediate family.
- Services or supplies furnished by any person or institution acting beyond the scope of his/her/its license.
- Services or supplies not specifically stated as covered.
- Services or supplies to the extent that the member or employee is not legally obligated to pay for them.
- Telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- Charges for any investigational or experimental treatment, procedure, facility, equipment, drug, device, or supply.
- Services and supplies for research studies or screening examinations, except as specifically stated in the Dental Benefits section of this booklet.

- Services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received.
- Treatment, services, supplies, or hospital care that, in the judgment of the Plan Administrator's dental consultants, are not medically/dentally necessary for the treatment of illness, injury, diseased condition, or impairment.
- Court ordered treatment that is not medically necessary.
- Treatment and care connected with, or incidental to, treatment that is primarily intended to improve appearance, including cosmetic or reconstructive surgery, when such procedures are performed to reshape normal structures of the body in order to improve the patient's appearance or self-esteem. However, benefits are provided for care and treatment intended to restore bodily functions or correct deformity resulting from disease, accidental injury, birth defects, or previous medical treatment.
- Treatment that is more intensive than is necessary based on the medical condition or symptoms alone require.
- Cosmetic surgery, services, and prescriptions, except when specifically stated as covered in this booklet.
- Services and supplies used to treat conditions to the extent that, according to generally accepted professional standards, such conditions are not amenable to favorable modification through medical or dental treatment.
- Charges for services or supplies for occupational accidents and diseases which are, or could have been paid for, or would be available under the requirements of the Worker's Compensation and Disease Law.
- Hospital, medical, or surgical services, supplies, or benefits to the extent that they are or could have been obtained under Medicaid.
- Any illness or injury that the Secretary of Defense or the Secretary of Veterans Affairs determines to be incurred in or aggravated by performance of service in the military.
- Treatment of any illness or injury sustained as a result of any act of war.
- Services or supplies received from a dental or medical department maintained by, or on behalf of a mutual benefit association, labor union, trust, or similar person or group.
- Services provided by any governmental agency to the extent that the member is not charged for them, except as may conflict with state or federal law.
- Over-the-counter drugs.
- Drugs not approved by the FDA, or found by the FDA to be ineffective.
- Experimental drugs including those labeled "Caution-Limited by Federal Law to Investigational Use."
- Vitamins, minerals, or supplements not requiring a prescription by law.
- Drugs prescribed for procedures, services, or conditions that are not covered under the health plan, including those prescribed for cosmetic purposes.

Section D - Definitions

Administrator – An organization or entity that Indiana University contracts with to provide administrative and claims payment services under the Plan. The Administrator is CIGNA Dental Health, Inc.

Balance Billing - The practice of billing the member for amounts (other than plan deductibles and copays) above covered charges, for Out-of-Network providers.

Copay/Copayment - The percentage or fixed amount of covered charges for which the member is responsible.

Covered Charges - Charges for covered services to the extent that, in the Plan Administrator's judgment, as authorized by the member's Plan Sponsor, are not excessive. The Plan Administrator will base its judgment on one or a combination of the following:

- A negotiated rate based on services provided
- The Usual and Reasonable (U&R) allowance for similar providers who perform like covered services

Covered Services - Services or supplies for which benefits will be paid when rendered by a dentist acting within the scope of his or her license. In order to be considered a covered service, charges must be covered by this plan, incurred while the member's coverage is in force, and supported by medical or other documentation by the provider as required by the Plan Administrator.

Deductible - The specified dollar amount of covered charges that the member must incur before the plan will assume any liability for all or part of the remaining covered charges.

Dentist - A person practicing dentistry or oral surgery within the scope of his/her license. It will also include a physician operating within the scope of his/her license when he/she performs any of the Dental Services described in the policy.

Dependent - A person of the employee's family who meets the eligible dependent guidelines in the Eligibility for Plan Membership section of this plan booklet.

Domestic Partner - An individual who has been registered by the employee with the university by submitting a notarized *Affidavit of Domestic Partnership* and supporting documentation, as is required by the Affidavit.

Effective Date - The date on which the member's coverage begins under the plan.

Emergency - A dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe that his or her condition requires immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection.

Eligible Person – A person who meets Indiana University's requirements and is entitled to apply to be a Subscriber.

Employee - Persons employed by Indiana University as full-time appointed Staff or Academic employees.

Experimental - see *Investigational/Experimental*.

Investigational/Experimental - Any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical treatment of the condition being treated, or any of such items requiring federal or other government agency approval not granted at the time the services were provided. The final determination as to whether one of the above items is investigational will be made, on behalf of the Plan Sponsor, by a medical policy committee of the Plan Administrator.

Limiting Age - In no case, except that of a fully-disabled child or where otherwise required by state law, shall a dependent child of the employee be eligible for coverage beyond the end of the month of the child's 24th birthday.

Medically/Dentally Necessary or Medical/Dental Necessity - Services or supplies received for treatment of an illness or injury or other health condition that is determined by the Plan Administrator, on behalf of the Plan Sponsor, to:

1. Be reasonable and appropriate;
2. Be consistent with the diagnosis or symptoms and condition;
3. Conform to commonly accepted standards throughout the dental field;
4. Not be investigative/experimental or unproven;
5. Not be excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment; and as to institutional care, cannot be provided in any other setting, such as a dentist's office or the outpatient department of a hospital, without adversely affecting the patient's condition;
6. Not be provided only as a convenience or preference to the member, dentist, other provider or person.

The fact that any particular provider may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment medically/dentally necessary or make a charge covered under this plan.

Member/Enrollee/Participant - A person provided coverage by the express terms of this plan, whether enrolled as an employee or as a dependent.

Non-Network Dentist or Specialist - A dentist that has not signed a contract to participate in the CIGNA PPO dental network.

Open Enrollment - The employee's annual opportunity to make changes to his or her dental coverage, adding or dropping dependents, or adding or dropping dental coverage. Changes outside the Open Enrollment period are subject to Internal Revenue Code Section 125, which limits changes to certain prescribed Changes in Status.

Plan - Any of the following that provides benefits or services for medical or dental care or treatment:

1. Group insurance and/or group-type coverage, whether insured or self-insured, which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
2. Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.

3. Medical benefits coverage of group, group-type, and individual automobile contracts. Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan.

Plan Membership - A member's or a dependent's right to benefits, subject to exclusions, limitations, and conditions described in this booklet.

Plan Sponsor - Indiana University.

Service Area - The geographical area in which CIGNA maintains dental networks and provides coverage.

Spouse - A person recognized as the member's husband or wife under the laws of the state of Indiana.

Usual and Reasonable (U&R) - The allowance measured and determined by comparing actual payments accepted by providers for similar services and supplies for individuals with similar medical conditions. When covered charges are based on the U&R allowance, the Plan Administrator, on behalf of the Plan Sponsor, will pay plan benefits up to the U&R allowance or billed charges, whichever is less.

Usual Fee - The amount that an individual dentist customarily charges patients for a service.

Section E — Claims/Appeals

FILING A DENTAL CLAIM

Network PPO dentists will submit claims for the member; non-PPO dentists may submit claims, but are not required to do so. If a member needs to submit a claim, forms are available from the campus Human Resources office. Claim forms can also be printed from the CIGNA Web site at *www.cigna.com*, or the University Human Resource Services Web site at *www.hr.iu.edu*.

Claim forms should be mailed to:

CIGNA Claims
P.O. Box 188037
Chattanooga, TN 37422-8037

For purposes of submitting claims, the IU Dental Plan Account Number is **3154192**.

Call CIGNA Member Services for a claim update or status.

Predetermination of Dental Benefits

It is recommended that claims over \$500 be submitted for predetermination to provide both the participant and dentist with an estimate of coverage. Requests for predetermination of benefits may be submitted to the claims address above.

APPEALING A DENTAL CLAIM

CIGNA has a two-step procedure for resolving complaints and appeals in a timely manner. Contact Member Services for additional information.

Level One Appeal (Complaint) The member must submit a written request to CIGNA within one year of the initial CIGNA Dental decision or occurrence. The appeal will be considered by someone not involved in the original decision. Issues involving dental necessity will be considered by a dental professional. Within 30 days, the member will receive a response or a notice as to why CIGNA cannot respond in that time. In all cases, the review will be completed within 45 days. If the member is not satisfied with the decision, he or she may request a Level Two review by submitting a written request within 60 days of the Level One Appeal decision.

Level Two Appeal CIGNA will acknowledge the member's Level Two appeal within five business days and provide additional contact information for the appeal coordinator. The appeal will be reviewed by a committee; in cases of dental necessity, a dentist will be included in the review. In cases of specialty care, a dentist of the same or similar specialty will be consulted. The member may present the situation to the committee in person or by conference call. Within 30 days, the member will receive a response or a notice as to why CIGNA cannot respond within that time. In all cases the review will be completed within 45 days. The member will be notified of the outcome within five business days of the committee review and the notification will include the specific contractual or clinical reason for the resolution, as applicable.

Expedited appeals may be requested in cases where the above process would seriously jeopardize the member's life, health, or ability to regain dental functionality that existed prior to the onset of the current dental condition.

If this above review process results in denial of coverage related to dental necessity or appropriateness of care, review by an Independent Review Organization may be available in the member's area. Contact Member Services for additional information.

Notice of Privacy Practices

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

Effective Date: April 14, 2003
Updated: September 2010

As the Plan Sponsor of employee health care plans, Indiana University considers personal health information to be confidential. We protect the privacy of that information in accordance with federal and state privacy laws, as well as the university's policy. We are required to give you notice of our legal duties and privacy practices, and to follow the terms of this notice currently in effect.

Who should read this Notice?

This notice applies to all employees covered under an IU-sponsored health plan.

How The Plan May Use and Disclose Protected Health Information about Members

Protected Health Information (PHI) is health information that relates to an identified person's physical or mental health, provision of health care, or payment for provision of health care, whether past, present or future and regardless of the form or medium, that is received or created by the Plan in the course of providing benefits under these Plans.

The following categories describe different ways in which Indiana University uses and discloses health information. For each of the categories Indiana University has provided an explanation and an example of how the information is used. Not every use or disclosure in a category will be listed. However, all of the ways Indiana University is permitted to use and disclose information will fall within one of the categories.

Treatment

Health information may be reviewed to provide authorization of coverage for certain medical services or shared with providers involved in a member's treatment. For example, the Plan may obtain medical information from or give medical information to a hospital that asks the Plan for authorization of services on the member's behalf, or in conjunction with medical case management or disease management programs.

Payment

Medical information may be used and disclosed to providers so that they may bill and receive payment for a member's treatment and services. For example, a member's provider may give a medical diagnosis and procedure description on a request for payment made to the Plan's claim administrator; and the claim administrator may request clinical notes to determine if the service is covered. Similarly, a physician may submit medical information to a Business Associate for purposes of administering wellness program financial incentives. Medical information may also be shared with

other covered entities for business purposes, such as determining the Plan's share of payment when a member is covered under more than one health plan.

Explanations of Payments are also mailed to the address of record for the employee, the primary insured.

Health Care Operations

Health information may be used or disclosed when information is needed to administer the Plan. For example, medical information may be reviewed by the manager of the provider network to evaluate provider performance with respect to network credentialing. Other examples of Plan administration may include activities such as quality management, administration of wellness programs and incentives, underwriting, detection and investigation of fraud, data and information system management; and coordination of health care operations between health plan Business Associates.

Individuals Involved in Your Care or Payment of Care

Unless otherwise specified, the plan may communicate health information in connection with the treatment, payment, and health care operations to the employee and/or any enrolled individual who is responsible for either the payment or care of an individual covered under the plan. Also, when a member authorizes another party in writing to be involved in their care or payment of care, the Plan may share health information with that party. For example, when an employee signs an authorization allowing a close friend to make medical decisions on his or her behalf, the Plan may disclose medical information to that friend.

Legal Proceedings, Government Oversight, or Disputes

Health information may be used or disclosed to an entity with health oversight responsibilities authorized by law, including HHS oversight of HIPAA compliance. For example, monitoring of government programs or compliance with civil rights laws. Health information may also be disclosed in response to a subpoena, court or administrative order, or other lawful request by someone involved in a dispute or legal proceeding.

Health – Related Services and Research

Medical information may be used to inform members about an upcoming health-related service or program to help members better manage a chronic condition. For example, a diabetes or asthma management program.

Uses and Disclosures Requiring Your Written Authorization

In all situations, other than the categories described above, we will ask for your written authorization before using or disclosing personal information about you. If you have given us an authorization, you may revoke it at any time, if we have not already acted on it.

Member Rights Regarding Protected Health Information

Right to Inspect and Copy

Members have the right to inspect and obtain a copy of the Protected Health Information maintained by the Plan including medical records and billing records.

To inspect and copy PHI, members must submit in writing a request to the plan administrator.

Requests to inspect and copy PHI may be denied under certain circumstances. If a member's request to inspect and copy has been denied written documentation stating the reason for the denial will be sent to the member.

Right to Amend

Members have the right to request an amendment to PHI if they feel the medical information is incorrect for as long as the information is maintained.

To request an amendment members must submit requests, along with a reason that supports the request, in writing to the plan administrator.

The Plan may deny a member's request for an amendment if it is not in writing or does not include a reason to support the request. Additionally, the Plan may deny a member's request to amend information that:

- Is not part of the information in which the member would be permitted to inspect or copy;
- Is not part of the information maintained by the Plan
- Is accurate and complete

Right to an Accounting of Disclosures

Members have the right to an accounting of PHI disclosures during the six years prior to the date of a request.

To request an accounting of disclosures, members must submit requests in writing to the plan administrator. Requests may not include permitted PHI disclosures made to carry out treatment, payment or health care operations included in the six categories listed above. The members written request must include a date or range of dates and may not include any dates before the April 14, 2003, compliance date.

Right to Request Restrictions

Members have the right to request restrictions on certain uses and disclosures of Protected Health Information to carry out treatment, payment or health care operations. Members also have the right to request a limit on the information the Plan discloses to someone who is involved in the payment of your care; for example: a family member covered under the plan.

The Plan is not required to agree to your request. To request restrictions, members must submit requests in writing to the Plan. Requests must include the following: (1) information the member wants to limit; (2) whether the member wants to limit our use, disclosure or both; and (3) to whom the member wants the limit to apply, for example, disclosures to a spouse.

Right to Request Confidential Communications

Members have the right to request that the Plan communicate with them about health information in a certain way or at a certain location. For example, asking that the Plan to contact members only at work.

To request confidential communications, members must submit requests in writing to Anthem, the health plan administrator and must include where and how members wish to be contacted. The Plan will accommodate all reasonable requests.

Right to a Paper Copy of This Notice

Members have the right to a paper copy of this Notice. To obtain a copy please contact the Privacy Administrator.

Changes Made to This Notice

The Plan reserves the right to change this Notice. The Plan reserves the right to make the revised or changed notice effective for Protected Health Information the Plan already has about members as well as any information received in the future. The Plan will make the notice available to members at all times.

How to File Complaints

If a member believes that their privacy rights have been violated, they may file a complaint to the Privacy Administrator at the following address:

Privacy Administrator
Poplars Building E165 400 E. Seventh Street
Bloomington, Indiana 47405-3085 (812) 855-6709

Members may file a complaint with the Secretary of the U.S. Department of Health and Human Services at the following address:

Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington D.C. 20201

Indiana University will not retaliate against any member for filing a complaint.

A Note About Personal Representatives

Members may exercise their rights through a personal representative. This person will be required to produce evidence of his/her authority to act on a member's behalf before they will be given access to PHI or allowed to take any action for a member. Proof of this authority may be one of the following forms:

- A power of attorney notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

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