



INDIANA UNIVERSITY
UNIVERSITY HUMAN RESOURCE SERVICES

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) PPO & HEALTH SAVINGS ACCOUNT

*Full-time Academic and Staff Employees
Summary of Plan Provisions*

Medical Coverage Administered by Anthem

Prescription Drug Coverage Administered by Anthem/Express Scripts

Mental Health/Chemical Dependency Coverage Administered by Anthem Behavioral Health

Health Savings Account Administered by JP Morgan Chase

JANUARY 2011

FOREWORD

This booklet describes the medical, pharmacy, and mental health/chemical dependency benefits that are provided by Indiana University through the HDHP PPO & Health Savings Account (HSA). Material in this booklet is for informational purposes only and is not intended to serve as legal interpretation of benefits. This booklet replaces and supercedes all plan documents the enrollee may have previously received.

All coverage information is intended to only describe benefits provided by this plan, and is not intended to limit or exclude services that members may elect.

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

Principal Features

The HDHP PPO & HSA combines:

- Comprehensive medical coverage, and
- A tax-advantaged savings account.

The HDHP PPO provides access to high quality health care through Anthem's Blue Access Provider Network. Benefits are provided when the member obtains Covered Services from Provider; however, the highest level of benefit is provided for services obtained from an In-Network Provider. The plan pays a large part of medical costs after the deductible is met and employee expenses are limited by an annual out-of-pocket maximum. The deductible is offset by university and employee contributions to the Health Savings Account.

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.

Administrative Services

Contact University Human Resource Services or refer to the Web site at www.hr.iu.edu for:

- Customer service telephone numbers;
- Information on COBRA continuation coverage;
- Claim forms;
- Name or address changes;
- Adding or removing dependents;
- To cancel coverage.

The benefits described are effective January 1, 2011.

Customer Service Information

Medical Coverage

For claims questions related to medical services, including information on medical Network Providers, call Anthem's IU Service Center at 800-345-2460, or go to www.anthem.com (select Blue Access PPO). For precertification of medical services, including all medical hospital admissions, call Anthem Health Care Management at 877-814-4803.

For information on Blue Cross and Blue Shield Network Providers outside Indiana, call 800-810-2583, or go to www.bluecares.com.

Prescription Drug Coverage

For information on retail prescription coverage, including participating pharmacies, call Anthem/Express Scripts at 866-216-5449 or go to www.anthem.com. For mail order prescriptions, call Anthem/Express Scripts at 866-216-5449 or go to www.anthem.com.

For information on specialty drugs call PrecisionRx Specialty Solutions at 1-800-870-6419.

Mental Health and Chemical Dependency Coverage

For prior authorization of all mental health and chemical dependency services, information on mental health and chemical dependency Network Providers, or questions about plan benefits or claims, call Anthem at 800-345-2460.

Health Savings Account

For information on the Health Savings Account, including contributions, withdrawals, account balances, and investment options, call JP Morgan Chase at 866-566-7101 or visit www.chasehsa.com.

24-Hour Nurse Line

For access to information and advice about medical issues 24 hours a day, 7 days a week, dial 866-895-5835 and press option #1 to speak with a Clarian Registered Nurse.

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High Deductible Health Plan (HDHP) PPO

Section A — General Provisions

ELIGIBILITY

Eligible Employees

Persons employed by Indiana University as full-time Academic or Staff employees are eligible for Plan Membership.

In addition to the University's eligibility requirements, the IRS has other enrollment requirements. The employee must:

- be a U.S. citizen or resident alien age 18 or older with a U.S. address (not a PO Box);
- have a valid Social Security Number;
- have no health coverage, as an employee or dependent, other than an HDHP except for certain IRS-allowed insurance, e.g., dental, vision, accident/disability, long-term care, per diem hospitalization, or specific disease coverage;
- not be enrolled in Medicare Part A or B (those eligible but not enrolled still qualify); and
- not be claimed as a dependent on anyone else's tax return.

NOTE: Domestic partners are eligible to be covered under an employee's HDHP; however, in accordance with IRS regulations, the University's savings account family contribution does not apply to a domestic partner that is not the employee's tax dependent and tax-free distributions cannot be made from the savings account for the partner's health expenses.

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 additions of newly eligible Dependents is effective as of the date of the *change of status* event, but only if the written request is received within 30 days of the event. 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 through Benefits Self Service 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 health care 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 health 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.

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:

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 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 can 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, 2010, 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

This Coordination of Benefits (COB) provision applies when enrollees or one of the enrollee's Dependents have health care coverage under more than one plan. Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of this booklet, e.g., plan. For

this provision only, “plan” will have the meanings as specified below. In the rest of the booklet, plan has the meaning listed in the Definitions section.

NOTE: Coordination of benefits does not apply to Outpatient prescription drug coverage. Outpatient prescription drug benefits are not extended to prescriptions purchased under the prescription benefits of another plan regardless of whether this Plan is primary or secondary.

The order of benefit determination rules determine the order in which each plan will pay a claim for benefits. The plan that pays first is called the *Primary Plan*. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another plan may cover some expenses.

The plan that pays after the Primary Plan is the *Secondary Plan*. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

The allowable expense under COB is generally the higher of the primary and Secondary Plans’ allowable amounts. A Network Provider can bill for any remaining Copay and/or Deductible under the higher of the plans’ allowable amounts. This higher allowable amount may be more than the plan’s Maximum Allowable Amount.

NOTE: When this Plan is secondary and the Primary Plan has benefits equal to or greater than this Plan, this Plan will probably not pay any benefits. This Plan does not cover the Deductible or penalties for not following Network and Health Care Management guidelines of the Primary Plan.

Coordination of Benefits Definitions

Closed Panel Plan is a plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Plan is any of the following that provides benefits or services for medical or dental care treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. *Plan includes:* Group and non group insurance contracts and Subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group Closed Panel Plans; Group-type contracts; Medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether “fault” or “no fault”); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. *Plan does not include:* Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or “to and from school” basis; and Medicare supplement policies.

Each contract for coverage under items 1 or 2 above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

Order of Benefit Determination Rules

When a Member or one of the Member's Dependents is covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

1. Except as provided in Rule 2 (two) below, a plan that does not contain a COB provision that is consistent with this COB provision is always primary, unless the provisions of both plans state that the complying plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide Non-Network benefits.

A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

Each plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The plan that covers the Member other than as a Dependent, for example as an employee, Member, policyholder, Subscriber, or Retiree is the Primary Plan, and the plan that covers the enrollee as a Dependent is the Secondary Plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent and primary to the plan covering the Member as other than a Dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Member as an employee, Member, policyholder, Subscriber, or Retiree is the Secondary Plan and the other plan covering the Member as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that

plan is primary. This rule applies to Plan Years commencing after the plan is given notice of the court decree;

- If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of item 1 (one), above, will determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of item 1 (one), above, will determine the order of benefits; or
- If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.

3. For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of item 1 (one) above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Separated Employee. The plan that covers the Member as an active employee, that is, an employee who is neither separated nor retired, is the Primary Plan. The plan also covering the Member as a retired or separated employee is the Secondary Plan. The same would hold true if the Member is a Dependent of an active employee and/or a Dependent of a retired or separated employee.

If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If covered under COBRA or under a right of continuation provided by state or other federal law and covered under another plan, the plan covering the Member as an employee, Member, Subscriber, or Retiree or as a Dependent of an employee, Member, Subscriber or Retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The plan that provided coverage longer is the Primary Plan and the plan that provided coverage for a shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the allowable expenses will be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on this Plan's Benefits

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Plan Year are not more than the total allowable expenses. In determining the amount to be paid for

any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim.

Because the allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill for any remaining Copay and/or Deductible under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB will not apply between that Plan and other Closed Panel Plans.

Right to Receive & Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. Anthem, on behalf of the Plan, may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Anthem need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Anthem any facts they need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, this Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by this Plan is more than should have been paid under this COB provision, Anthem, on behalf of Indiana University, may recover the excess from one or more of the persons:

1. The Plan has paid or for whom the Plan has paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

MEDICARE

In order to participate in the Health Savings Account Benefit, the Subscriber cannot be enrolled in Medicare. However, a spouse or dependent can be a Medicare enrollee.

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor

legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law. Except when federal law requires the Plan to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Member to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Parts B and/or D, the Plan will calculate benefits as if they had enrolled.

For Medicare Part D no Prescription Drug benefits will be payable under this Plan unless the Member has enrolled in Part D. For Medicare Part D the Plan will calculate benefits as if the Member had enrolled in the Standard Basic Plan.

Worker's Compensation

The benefits under the Plan are not designed to duplicate benefits that Members are eligible for under the Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to a Member shall be paid back by, or on behalf of, the Member to the Plan if the Plan has made or makes payment for the services received. It is understood that coverage under the Plan does not replace or affect any Worker's Compensation coverage requirements.

Other Government Programs

The benefits under the Plan shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to the Plan.

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 that allows an employee to drop and then resume IU-sponsored health 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 HDHP PPO & Health Savings Account 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 health care plan in the same year, the employee must resume the health plan election that was in place at the time that participation was terminated. (IRS provision for preferential tax treatment of all contributions.)

CONTINUATION OF COVERAGE UPON LOSS OF ELIGIBILITY

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

COBRA

The University offers employees and their covered Dependents the opportunity for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where coverage under the plan would otherwise end. A detailed description of these COBRA provisions should 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 health care coverage, or an eligible Dependent otherwise becomes qualified for COBRA benefits.

If the employee is covered under the plan, each of the qualified beneficiaries listed in the Changes of Status and Qualified Beneficiaries section has the right to choose continuation coverage if his or her coverage under the plan would otherwise end. The election period lasts for 60 days and begins on the later of either the date that the qualified beneficiary would lose coverage due to the change of status, or the date the qualified beneficiary is sent notice of the right to continuation coverage.

Unless the election specifies otherwise, an election by a covered employee or a spouse is also considered an election on behalf of any other qualified beneficiary who would also lose coverage due to that change of status.

For purposes of this section, *entitled to Medicare* means the Effective Date of enrollment in Medicare Part A or B, under Title XVIII of the Social Security Act, as amended. Eligibility to enroll in Medicare does not have the same meaning as entitled to Medicare.

Changes of Status and Qualified Beneficiaries

The following qualified beneficiaries have the right to continuation coverage when one of the following changes of status results in a loss of coverage under the plan:

1. Upon the death of the covered Subscriber: the spouse and Dependent children;
2. Upon the covered Subscriber's termination (for other than gross misconduct) or reduction in work hours: the Subscriber and his or her eligible Dependents;
3. Upon the divorce or legal separation of the covered Subscriber: the divorced or legally separated spouse and Dependent children;
4. Upon the covered Subscriber becoming entitled to Medicare under Title XVIII of the Social Security Act: the spouse and Dependent children;
5. Upon the disqualification of a Dependent child under the plan's eligibility requirements: the Dependent child not meeting such requirements;
6. Upon Indiana University's filing of a Title XI Bankruptcy: the retired covered Subscriber and his or her Dependents who:
 - a. As a result of the bankruptcy filing would experience a substantial elimination of health coverage, under the plan, within a year of the bankruptcy filing; or
 - b. Has experienced an elimination of coverage during the year preceding the bankruptcy filing.

For the purposes of this section, coverage for a Dependent child includes coverage for any child born to, or placed for adoption with, a qualified beneficiary after a change of status if proper notice is provided to the plan of the birth or adoption.

If a spouse or dependent child of a subscriber is covered through a subscriber by alternative coverage, and the right to receive the alternative coverage will cease upon the death of, or divorce or legal separation from, the subscriber, the end of the alternative coverage shall be considered a change of status as described in paragraphs 1 and 3 in this section (Changes of Status and Qualified Beneficiaries), regardless of whether the alternative coverage would satisfy COBRA continuation coverage rules.

Alternative coverage means coverage provided by an employer without regard to COBRA continuation coverage, as a result of state or local law, industry practice, a collective bargaining or severance agreement, plan procedure, or disability or workers compensation leave.

Duration of Continuation Coverage

1. For the events explained in paragraphs 1, 3, 4 and 5 under Changes of Status and Qualified Beneficiaries, continuation coverage is provided for 36 months after the date of the initial change of status.
2. For the changes explained in paragraph 2 under Changes of Status and Qualified Beneficiaries, continuation coverage is provided for 18 months after the date of the change of status.

Exceptions:

- a. If the change of status in paragraphs 1, 3, 4, and 5 under Changes of Status and Qualified Beneficiaries occurs during the 18-month period, continuation coverage will be continued an additional 18 months;
or
 - b. If a qualified beneficiary is determined under Titles II or XVI of the Social Security Act to be disabled at any time during the first 60 days of continuation coverage under paragraph 2 under Changes of Status and Qualified Beneficiaries, continuation coverage will be extended an additional 11 months and billed at 150 percent of the premium. However, coverage will be extended only if the qualified beneficiary gives notice of the disability within 60 days after the disability is determined and before the end of the original 18-month continuation period. When the qualified beneficiary is no longer disabled, he or she must notify Indiana University within 30 days after the final determination is made under Titles II and XVI; or
 - c. If the Subscriber became entitled to Medicare prior to the change of status, the period of coverage for qualified beneficiaries other than the Subscriber shall be the longer of 18 months from the termination or reduction in hours of employment or 36 months from the earlier Medicare entitlement.
3. For the event explained in paragraph 6 under Changes of Status and Qualified Beneficiaries, continuation coverage is provided until the death of the retired covered Subscriber. If the covered Subscriber dies before the occurrence of the change of status, continuation coverage is provided until the death of the surviving spouse. Upon the death of the covered Subscriber, his or her Dependents (other than a surviving spouse entitled to lifetime coverage) are entitled to continuation coverage as explained in paragraph 1 under Changes of Status and Qualified Beneficiaries.

The maximum period for all changes of status is 36 months, except as may occur under paragraph 3 under Duration of Continuation Coverage.

Premiums

The qualified beneficiary must pay premiums for any period of continuation coverage. If the qualified beneficiary makes the election after the change of status, any premiums due must be paid within 45 days after the date of the election.

Cancellation

Continuation coverage will terminate:

- If the Plan Sponsor ceases to provide any group health plan to its Members;
- If premiums are not paid on time;

- Upon the date, after the date of continuation coverage election, the qualified beneficiary first becomes covered under another group health plan that:
 - Does not contain any limitation regarding a Pre-Existing Condition of the beneficiary; or
 - Does contain a pre-existing exclusion or limitation that would apply to the beneficiary but is not applicable because of the Federal Health Insurance Portability and Accountability Act of 1996's rule on Pre-Existing Condition clauses;
- Upon the date, after the date of continuation coverage election, a qualified beneficiary other than beneficiaries that are provided continuation of coverage under paragraph 6, under Changes of Status and Qualified Beneficiaries, first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
- A qualified beneficiary who was disabled under paragraph 2, under Changes of Status and Qualified Beneficiaries, is no longer disabled. The additional 11 months of extended continuation coverage will be terminated on the first day of the month that begins more than 30 days after the date of the final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled.

When the University is notified that an employee has experienced an event that qualifies them for continuation coverage, Indiana University should notify the participant of his or her right to choose continuation coverage. If the participant does not choose COBRA continuation coverage, benefits under this Plan will end, based on the provisions described in the section Termination of Coverage (see page 48).

USERRA HEALTH PLAN PROTECTION

If an employee terminates employment in order to perform military service, the employee has the right under USERRA to elect to continue existing IU-sponsored health plan coverage including coverage for his or her Dependents for up to 24 months while in the military. The University administers this coverage by extending the employee's COBRA eligibility period to a total of 24 months. The employee is responsible for the entire premium plus a 2 percent administration fee.

Even if the employee doesn't elect to continue coverage during military service, he or she has the right to be reinstated in an IU-sponsored health plan upon reemployment, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

This is an overview of USERRA health plan coverage rights and actual coverage may vary depending on circumstances.

For additional information on USERRA health plan rights, contact the Veteran's Employment & Training Service (VETS) at 1-866-4-USA-DOL or visit their website at www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at www.dol.gov/elaws/userra.htm.

If the employee was covered by this Plan at the time of termination and meets the qualifications for IU Retiree status, the employee may participate in an IU-sponsored Retiree health care plan available at that time. Please contact a campus Human Resources office to initiate such an enrollment.

Section B — Schedule of Benefits

The Schedule of Benefits is a summary of the Deductibles, Copays, maximums, and other limits that apply to Covered Services obtained from a Covered Provider. Please refer to the "Covered Services" section of this Benefit Booklet for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet.

Plan Year: Benefits are based on a calendar Plan Year, January 1 to December 31.

PPO Network: Anthem Blue Access.

Dependent Age Limit: Age 25 or under (eligibility ends at the end of the month in which the child reaches age 26), unless the Dependent qualifies for Disabled Child Eligibility.

Lifetime Maximums: None

Pre-Existing Condition Limitations: None

Maximum Allowable Amount

This amount is also sometimes referred to as Covered Charges, Usual & Reasonable (U&R) charges, or Usual & Customary (U&C) charges. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. Network Providers accept the Maximum Allowable Amount as payment in full.

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 Coinsurance, Copayments, Deductibles, and/or non-covered charges. Copayments/Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

Deductible

Deductible means the specified dollar amount of covered charges that must be incurred by the Member before Anthem will begin to pay benefits for the remainder of the calendar year. 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.

Network	Non-Network
\$1,200 for Employee-only Coverage	\$2,400 for Employee-only Coverage
\$2,400 when one or more family members are covered (all other coverage levels)	\$4,800 when one or more family members are covered (all other coverage levels)

All Covered Services are subject to the Deductible except for wellness/preventive services.

Out-of-Pocket Maximum

All Deductibles and Copays apply toward the Out-of-Pocket Maximum including prescription drugs. This excludes Non-Network Human Organ and Tissue Transplants. Once the employee-only or family Out-of-Pocket Maximum is satisfied, no additional Copay/Coinsurance will be required for the member or family for the remainder of the Plan Year except for Non-Network Human Organ and Tissue Transplant services.

Network	Non-Network
\$2,500 for Employee-only Coverage	\$5,000 for Employee-only Coverage
\$5,000 when one or more family members are covered (all other coverage levels)	\$10,000 when one or more family members are covered (all other coverage levels)

Network and Non-Network Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximums are separate and do not accumulate toward each other.

MEDICAL BENEFITS

This Schedule lists the Member's responsibility for Covered Services. To receive maximum benefits at the lowest Out-of-Pocket expense, Covered Services must be provided by a Network Provider.

MEDICAL SERVICE/PROCEDURE	MEMBER RESPONSIBILITY	
	Network Provider	Non-Network Provider
Physician Home and Office Services Including Office surgeries, allergy serum, allergy injections, and allergy testing.	20%	40%
Preventive Care Services Services include but are not limited to routine exams, mammograms, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision, and hearing exams. Network Preventive Care - not subject to deductible Non-Network Preventive Care - subject to deductible <ul style="list-style-type: none"> Physician Home and Office Visits Other Outpatient Services, Outpatient Facility @ Hospital/ Alternative Care Facility 	No copay or deductible.	40%
Dental Services (Accidental) Only covered when related to accidental dental injury or for certain Members requiring anesthesia.	20%	40%
Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room Services - facility and other covered services (copay waived if admitted) Urgent Care Center Services 	20%	20%

MEDICAL SERVICE/PROCEDURE	MEMBER RESPONSIBILITY	
	Network Provider	Non-Network Provider
<p>Inpatient and Outpatient Professional Services Include but are not limited to:</p> <ul style="list-style-type: none"> • Medical care visits (1 per day), intensive medical care, concurrent care, consultations, surgery, and administration of general anesthesia and newborn exams. 	20%	40%
<p>Maternity Services</p>	Covered as any other illness; subject to same Copays, Deductibles, and maximums.	
<p>Inpatient and Outpatient Professional Services Include but are not limited to:</p> <ul style="list-style-type: none"> • Medical care visits (1 per day), intensive medical care, concurrent care, consultations, surgery, and administration of general anesthesia and newborn exams. 	20%	40%
<p>Inpatient Facility Services Network/Non-Network Combined Unlimited days except for:</p> <ul style="list-style-type: none"> • Unlimited days Network/60 days Non-network for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • Unlimited days Network/Non-network combined for skilled nursing facility. 	20%	40%
<p>Outpatient Surgery Hospital/Alternative Care Facility</p> <ul style="list-style-type: none"> • Surgery and administration of general anesthesia. 	20%	40%
<p>Other Outpatient Services Network/Non-Network Combined Including but not limited to:</p> <ul style="list-style-type: none"> • Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services (Unlimited Network/30 visits Non-network (excludes IV Therapy)) • Durable Medical Equipment and Orthotics • Prosthetic Devices • Prosthetic limbs • Physical Medicine Therapy Day Rehabilitation Programs • Hospice Care • Ambulance Services 	20%	40%

MEDICAL SERVICE/PROCEDURE	MEMBER RESPONSIBILITY	
	Network Provider	Non-Network Provider
<p>Outpatient Therapy Services Network/Non-Network Combined</p> <ul style="list-style-type: none"> • Physician Home and Office Services • Other Outpatient Services @ Hospital/Alternative Care Facility <p>Maximum Therapy Visits per Plan Year: Physical Therapy - 60 visits Occupational Therapy - 60 visits Speech Therapy - 20 visits Manipulation Therapy - 12 visits Cardiac Rehab – Unlimited Pulmonary Rehab – Unlimited Dialysis Treatments – Unlimited Chemotherapy - Unlimited Radiation Therapy – Unlimited Inhalation Therapy – Unlimited</p> <p>NOTE: Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copay, regardless of the setting where the services are received.</p>	20%	40%
<p>Behavioral Health Services Mental Illness and Substance Abuse:</p> <ul style="list-style-type: none"> • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Services (PCP/SCP) 	20%	40%
<p>Human Organ and Tissue Transplants</p> <p>The human organ and tissue transplant services benefits or requirements described below do not apply to the following:</p> <ul style="list-style-type: none"> • Cornea and kidney transplants; and • Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. <p>Transplant Benefit Period</p>	20%	50% of the Maximum Allowable Amount.
	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period.	Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

MEDICAL SERVICE/PROCEDURE	MEMBER RESPONSIBILITY	
	Network Provider	Non-Network Provider
<p>Human Organ and Tissue Transplants cont.</p> <p>Deductible</p>		<p>During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to the Out-of-Pocket Limit.</p>
<p>Covered Transplant Procedure during the Transplant Benefit Period</p>	20%	<p>50% of the Maximum Allowable Amount.</p> <p>During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to the Out-of-Pocket Limit.</p> <p>If the Provider is also a Network Provider for the Plan (for services other than Transplant Services and Procedures), then the Member will not be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount.</p> <p>If the Provider is a Non-Network Provider for the Plan, the Member will be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount.</p>
<p>Transportation and Lodging</p>	Covered, as approved by the Plan, up to a \$10,000 benefit limit.	Not Covered

MEDICAL SERVICE/PROCEDURE	MEMBER RESPONSIBILITY	
	Network Provider	Non-Network Provider
Human Organ and Tissue Transplants cont. Live Donor Health Services	Covered as determined by the Plan	Covered as determined by the Plan. These charges will NOT apply to the Out-of-Pocket Limit.

NOTES:

- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-Network Human Organ and Tissue Transplants).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance including prescription drugs.
- Network and Non-Network deductibles, coinsurance, and out-of-pocket maximums are separate and do not accumulate toward each other.
- No copayment/coinsurance or 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-Network provider, the member is responsible for any balance due after the plan payment.
- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-Network Human Organ and Tissue Transplants).
- Benefit Period = Calendar Year
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits.

MEDICAL SERVICE/PROCEDURE	MEMBER RESPONSIBILITY	
	Network Pharmacy	Non-Network Pharmacy
Prescription Drugs		
Retail Pharmacy Prescription Drugs (Up to 30-day supply) NOTE: Speciality Drugs ¹ are not covered at Retail.	20% (No Deductible on Preventive R _x) ²	40%
Mail Service Pharmacy Prescription Drugs (Up to 90-day supply) and Speciality Drugs ¹	20% (No Deductible on Preventive R _x) ²	Not Covered.
Non-covered Prescription Drugs	100% with Network Discount	100%
Orally Administered Cancer Chemotherapy Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when obtained from a Network Pharmacy, Mail Service Program, Specialty Pharmacy Network, or Non-Network Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.		

¹ **Speciality Drugs:** High cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through mail order.

² Preventive prescriptions that are not subject to the deductible can be found at hr.iu.edu/benefits/2011/hdhp-rx.pdf.

Section C — Covered Services

This section describes the Covered Services available under this health care Plan when provided and billed by Network Providers. **For most services, care must be received from a Network Provider to be a Covered Service.** The amount payable for Covered Services varies depending on whether the services received are from a Network Provider or a Non-Network Provider, except for Emergency Care services.

If a Non-Network Provider is used, the Member is responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copay or Deductible. The Plan cannot prohibit Non-Network Providers from billing for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

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 or a Covered Service 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. Anthem bases its decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Anthem's clinical coverage guidelines and medical policy. Anthem 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 Copay, Deductible, Plan Year Limit/Maximum, or Lifetime Maximum in this Benefit Booklet.**

AMBULANCE SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- From a Member's home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to a Member's home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when not transported will be covered if Medically Necessary. Other vehicles which do not meet this definition, including but not limited to ambulances, are not Covered Services. Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an Employer, school, fire or public safety official and the Member is not in a position to refuse; or

- When a Member is required by the Plan to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for the condition. If none of these facilities are in the local area, Members are covered for trips to the closest facility outside the local area. Ambulance usage is not covered when another type of transportation can be used without endangering the member's health. Any ambulance usage for the convenience of the Member, family, or Physician is not a Covered Service.

Non-Covered Services for Ambulance include but are not limited to, trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

BEHAVIORAL HEALTH SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Covered Services include but are not limited to:

- **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family members to assist in diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.
- **Partial hospitalization** – an intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.
- **Intensive Outpatient treatment or day treatment** – a structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs generally provide 3 hours of treatment per day, and the program is generally available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.
- **Outpatient treatment, or individual or group treatment** – office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient. To assist in obtaining appropriate and quality care, Anthem will ask the treating Provider to submit a treatment plan after 10 Outpatient visits. Anthem may discuss the goals of treatment and changes in the treatment plan, including alternative courses of treatment, with the Provider in order to manage benefits effectively and efficiently.

Non-Covered Behavioral Health Services (please also see the Exclusions section of this Benefit Booklet for other non-Covered Services)

- Custodial or Domiciliary Care.
- Supervised living or halfway houses.
- Services or care provided or billed by a residential treatment center, school, halfway house,
- Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

- Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.

DENTAL SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from 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.

Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- 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. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

DIAGNOSTIC SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Diagnostic Services are tests or procedures generally performed when specific symptoms are present to detect or monitor the patient's condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).

- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocardiograms.

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

For Diagnostic Services other than those approved to be received in a Physician's office, the Member may receive the lowest out-of-pocket expenses by using Anthem's cost effective Independent Laboratory Network Provider called the Reference Laboratory Network (RLN). When Diagnostic Services are performed within 3 days (72 hours) as part of pre-admission testing required for an Inpatient admission or an Outpatient surgery, any Copay will still apply. When Diagnostic radiology is performed in a Network Physician's Office, any Copay from a Network or a Non-Network Physician will still apply.

EMERGENCY CARE AND URGENT CARE SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Emergency Care (including Emergency Room Services)

Medically Necessary services which Anthem determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copay or Deductible. In certain circumstances, Emergency Care received from a Non-Network Provider may be approved as an Authorized Service. Members must contact Anthem 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. Whenever admitted as an Inpatient directly from a Hospital Emergency room, the Emergency Room Services Copay for that Emergency Room visit will be waived.

For Inpatient admissions following Emergency Care, Precertification is not required. However, the Member must notify Anthem, on behalf of the Plan, or verify that their Physician has notified Anthem of the admission within 48 hours or as soon as possible within a reasonable period of time. When Anthem 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 Anthem or is a BlueCard Provider, the Member will be financially responsible for any care Anthem, on behalf of the Plan, determines is not Medically Necessary.

The Behavioral Health Services Subcontractor also 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 a Non-Network Provider beyond that needed to evaluate or Stabilize the condition in an Emergency will be covered as a Non-Network service unless Anthem authorizes the continuation of care and it is Medically Necessary.

Urgent Care Center Services

All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copay. Urgent Care services can be obtained from a Network or Non-Network Provider. However, to receive maximum benefits Urgent Care services must be obtained from a Network Provider. Urgent Care Services received from a Non-Network Provider will be covered as a Non-Network service and the Member will be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copay or Deductible. 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.

HOME CARE SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Covered Services are those performed by a Home Health Care Agency or other Provider in the Member's residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis.

Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional Guidance.
- 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 Anthem, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- 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.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Non-Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a Member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if prior approval is obtained from Anthem's Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include 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 (intramuscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

HOSPICE SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months. When approved by the Member's Physician,

Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide.

Non-Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services

INPATIENT SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that a private room is used for isolation and no isolation facilities are available.
- A room in a special care unit approved by Anthem, on behalf of the Plan. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Services.
- Therapy Services.

Professional Services

- Medical care visits limited to one visit per day by any one Physician.
- Intensive medical care for constant attendance and treatment when a condition requires it for a prolonged time.
- Concurrent care for a medical condition by a Physician who is not the Member's surgeon while in the hospital for surgery. Care by two or more Physicians during one hospital stay when the nature or severity

of the condition requires the skills of separate Physicians.

- Consultation which is a personal bedside examination by another Physician when requested by the Member's Physician. Staff consultations required by hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

MATERNITY SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Maternity services include Inpatient Services, Outpatient Services, Physician Home Visits, and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), 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.

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 Anthem.

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, and will be subject to a separate Inpatient Copay. If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for a Member and her newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the attending Physician determines further Inpatient postpartum care is not necessary for the Member or the newborn child, provided the following are met and the mother concurs:

- In the opinion of the attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. the antepartum, intrapartum, and postpartum course of the mother and infant;
 2. the gestational stage, birth weight, and clinical condition of the infant;
 3. the demonstrated ability of the mother to care for the infant after discharge; and

4. the availability of post-discharge follow-up to verify the condition of the infant after discharge.
- Covered Services include at-home post delivery care visits at the Member's residence by a Physician or Nurse performed no later than 48 hours following discharge from the Hospital. At the Member's discretion, this visit may occur at the Physician's office. Coverage for this visit includes, but is not limited to:
 1. parent education;
 2. assistance and training in breast or bottle feeding; and
 3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for a Member or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

In addition, coverage is provided for an examination given at the earliest feasible time to a newborn child for the detection of the following disorders:

- Phenylketonuria.
- Hypothyroidism.
- Hemoglobinopathies, including sickle cell anemia.
- Galactosemia.
- Maple Syrup urine disease.
- Homocystinuria.
- Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health.
- Physiologic hearing screening examination for the detection of hearing impairments.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary or needed to treat the condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary.

Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is the Member's responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates the condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Anthem, on behalf of the Plan. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

Covered Services — Continued

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).
- In addition, replacement of purchased equipment, supplies or appliance may be covered if:
 1. The equipment, supply or appliance is worn out or no longer functions.
 2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
 3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
 4. The equipment, supply or appliance is damaged and cannot be repaired.

Anthem, on behalf of the Plan may establish reasonable quantity limits for certain supplies, equipment or appliance described below. A detailed listing of supplies, equipment or appliances that are not covered by the Plan including quantity limits, is available upon request. Call the customer service number on the Identification Card or visit Anthem's website at www.anthem.com. This list is subject to change.

Covered Services may include, but are not limited to:

Medical and surgical supplies—Certain supplies and equipment for the management of disease that Anthem approves are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Anthem's Prescription Drug benefit or if the supplies, equipment or appliances are not received from the Anthem Mail Service or from a Network Pharmacy. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Prescription Drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depo-Provera. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1. Allergy serum extracts
2. Chem strips, Glucometer, Lancets,
3. Clinitest
4. Elastic stockings or supports. These items must be purchased by prescription or through a Hospital. They must be Medically Necessary for the treatment of an injury or condition requiring stockings. The Plan may establish reasonable limits on the number of pairs allowed per Member per Plan Year.
5. Needles/syringes
6. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

Non-Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators
2. Arch supports
3. Doughnut cushions
4. Hot packs, ice bags
5. Vitamins
6. Medijectors

Durable medical equipment—The rental (or, at the Plan’s option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient’s home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. Equipment should be purchased when it costs more to rent it than to buy it.

The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately.

Repair of medical equipment is covered. Certain life sustaining equipment, as approved by Anthem, is not subject to the durable medical equipment maximum. Some examples of such equipment include, but are not limited to, certain ventilator and respiratory assist devices and chest percussion devices (for cystic fibrosis).

Any questions regarding whether a specific piece of durable medical equipment has been approved by Anthem as life sustaining equipment should be directed to the customer service number on the back of the Identification Card.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors
8. Augmentive communication devices are covered when Anthem approves based on the Member’s condition.

Non-covered items may include but are not limited to:

1. Air conditioners
2. Ice bags/cold pack pump
3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

Prosthetics—Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices 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.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft 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) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Plan Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
5. 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.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer treatment, not to exceed one per Plan Year).

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
5. Artificial heart implants.
6. Wigs (except as described above following cancer treatment).
7. Penile prosthesis in men suffering impotency resulting from disease or injury.

Orthotic devices—Covered Services are the initial purchase, fitting, and repair of a custom made 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 included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.

3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per Plan Year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired. Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

Prosthetic limbs & Orthotic custom fabricated brace or support - Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1. determined by a Physician to be Medically Necessary to restore or maintain the ability to perform activities of daily living or essential job related activities; and
2. not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible and Copay provisions otherwise applicable under the Plan. They are also subject to a separate Lifetime Maximum and do not apply to the Plan Lifetime Maximum.

OUTPATIENT SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Anthem, on behalf of the Plan.

Professional charges only include services billed by a Physician or other professional. When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, any Copay will still apply to these services.

PERVASIVE DEVELOPMENTAL DISORDER SERVICES

Coverage is provided for the treatment of pervasive developmental disorders. Treatment is limited to services prescribed by a Physician in accordance with a treatment plan. Pervasive developmental disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Any exclusion or limitation in this Benefit Booklet in conflict with the coverage described in this provision will not apply. Coverage for pervasive developmental disorders will not be subject to dollar limits, Deductibles, and/or Copay provisions that are less favorable than the dollar limits, Deductibles, and/or Copay provisions that apply to physical illness under this Plan.

PHYSICIAN HOME VISITS AND OFFICE SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Covered Services include care provided by a Physician in their office or the Member's home. Refer to the sections titled "Preventive Care", "Maternity Care", and "Home Care Services" for services covered by the Plan. For Emergency Care refer to the "Emergency Care and Urgent Care" section.

Office Visits—for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copay is required.

Home Visits—for medical care and consultations to examine, diagnose, and treat an illness or injury performed in a Member's home.

Diagnostic Services—when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical Services (including anesthesia and supplies)—the surgical fee includes normal post-operative care.

Therapy Services—for physical medicine therapies and other Therapy Services when given in the office of Physician or other professional Provider.

PREVENTIVE CARE SERVICES

Preventive Care services include Inpatient services, Outpatient services, Physician Home Visits, and Office Services. These services may vary based on the age, sex, and personal history of the individual, and as determined appropriate by U.S. Preventive Services Task Force (USPSTF) guidelines.

Screenings and other services are generally 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.

Some examples of Preventive Care Covered Services are:

Routine or Periodic Exams—Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services. Examinations include, but are not limited to:

1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
2. Adult routine physical examinations.
3. Pelvic examinations.
4. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
5. Annual dilated eye examination for diabetic retinopathy.

Immunizations—(including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

For adults, the Plan follows the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians.

These include, but are not limited to:

1. Hepatitis A vaccine.
2. Hepatitis B vaccine.
3. Hemophilus influenza b vaccine (Hib).
4. Influenza virus vaccine.
5. Rabies vaccine.
6. Diphtheria, Tetanus, Pertussis vaccine.
7. Mumps virus vaccine.
8. Measles virus vaccine.
9. Rubella virus vaccine.
10. Poliovirus vaccine.

Screening Examinations

1. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts.
2. Routine hearing screening.
3. Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for screening of breast cancer, if determined Medically Necessary by a

Physician, are also covered.

4. Routine cytologic and chlamydia screening (including pap test).
5. Routine bone density testing for women.
6. Routine prostate specific antigen testing.
7. Routine colorectal cancer examination and related laboratory tests.

Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by the Member's Physician.

Diabetes Self Management Training—for an individual with insulin Dependent diabetes, non-insulin Dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Medical Nutritional Therapy—limited to consultations for the Medically Necessary management and treatment of obesity. Any Prescription Drug or medical supply prescribed as a part of this therapy will not be covered except as otherwise stated under this Benefit Booklet. This therapy is limited to services rendered by Network Providers. Charges for Medical Nutritional Therapy from a Non-Network Provider are not covered under the Plan.

SURGICAL SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as approved by Anthem, on behalf of the Plan.

The surgical Fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Anthem for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;

- Invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services—Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan.

Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy. See “Mastectomy Notice” below for further coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon’s disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice—A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending Physician and will be subject to the same annual Deductible and Copay provisions otherwise applicable under the Plan.

Sterilization—Sterilization is a Covered Service.

THERAPY SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

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:

Physical Medicine Therapy Services—The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

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.

Speech therapy for the correction of a speech impairment.

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 rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

Manipulation Therapy includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations 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 any maximum for Manipulation Therapy Services as specified in the Schedule of Benefits. Manipulation Therapy Services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

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.

Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

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 a Non-Network Dialysis Facility nearest to their home as an Authorized Service.

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.

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; nonpressurized 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.

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.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- Cornea and kidney transplants; and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.

Please note that the initial evaluation and any necessary additional testing to determine eligibility as a

candidate for transplant by a Provider, and the harvest and storage of bone marrow/stem cells, is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services, Physician Home Visits, and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure—Any Medically Necessary human organ and tissue transplants or transfusions as determined by Anthem, on behalf of the Plan, including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period—The Transplant Benefit Period starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 -50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility or the later of 30 days or date of discharge following a Covered Transplant Procedure at a Non-Network Transplant Provider Facility.

Prior Approval and Precertification—In order to maximize benefits, potential transplant candidates are strongly encouraged to call Anthem’s transplant department to discuss benefit coverage when it is determined a transplant may be needed. This must be done before an evaluation and/or work-up for a transplant. Anthem will assist Members in maximizing benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of the Identification Card and **ask for the transplant coordinator**. Even if Anthem issues a prior approval for the Covered Transplant Procedure, the Member or Provider must call Anthem’s Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that 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.

Transportation, Meals and Lodging—The Plan will provide assistance with reasonable and necessary travel expenses as determined by Anthem, on behalf of the Plan, when a Member obtains prior approval and is required to travel more than 75 miles from their residence to reach the facility where the Covered Transplant Procedure will be performed. The Plan’s assistance with travel expenses includes transportation to and from the facility and lodging and meals for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging, and meals may be allowed for two companions. The Member must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to Anthem when claims are filed. Contact Anthem for detailed information.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

PRESCRIPTION DRUG BENEFITS

See the Schedule of Benefits for any applicable Deductible, Copay, and/or Benefit Limitation information.

Pharmacy Benefits Manager—The pharmacy benefits available to Members under the Plan are managed by Anthem’s Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which Anthem contracts to manage your pharmacy benefits. The PBM has a nationwide Network of retail pharmacies, a Mail Service pharmacy, a Specialty Pharmacy Network, and provides clinical management services. The management and other services the PBM provides include, among others, making recommendations to, and updating, the Covered Prescription Drug List (also known as a Formulary) and managing a Network of retail pharmacies, operating a Mail Service pharmacy, and a Specialty Drug Pharmacy Network. The PBM, in consultation with Anthem, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may also request a copy of the Covered Prescription Drug List by calling Anthem at the Customer Service telephone number on the back of your Identification Card. The Covered Prescription Drug List is subject to periodic review and amendment. **Inclusion of a Drug or related item on the Covered Prescription Drug List is not a guarantee of coverage.**

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/ Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Plan can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy’s computer system. Anthem, or the PBM, use pre-approved criteria, developed by Anthem’s Pharmacy and Therapeutics Committee which is reviewed and adopted by Anthem. Anthem or the PBM may contact your Provider if additional information is required to determine whether Prior Authorization should be granted. If Prior Authorization is denied, you have the right to Appeal through the Appeals process outlined in the Member Grievances section of this Benefit Booklet. For a list of the current Drugs requiring Prior Authorization, please contact Anthem at the Customer Service telephone number on the back of your ID Card.

Therapeutic Substitution of Drugs is a program approved by Anthem and managed by the PBM. This is a voluntary program designed to inform Members and Physicians about possible alternatives to certain prescribed Drugs. Anthem, or the PBM, may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you.

For questions or issues involving therapeutic Drug substitutes, contact Anthem by calling the Customer Service telephone number on the back of your ID Card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

Step Therapy protocol means that a Member may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Specialty Pharmacy Network

Anthem's Specialty Pharmacy Network is available to Members who use Specialty Drugs. "Specialty Drugs" are Prescription Legend Drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Network Specialty Pharmacies may fill Mail Service Specialty Drug Prescription Orders, subject to the applicable Copay shown in the Schedule of Benefits. Network Specialty Pharmacies have dedicated patient care coordinators to help manage conditions and offer toll-free twenty-four hour access to nurses and registered Pharmacists to answer questions regarding medications. A list of the Network Specialty Pharmacies may be obtained, including covered Specialty Drugs, by calling the Customer Service telephone number on the back of the ID Card, or by reviewing the lists on Anthem's website at www.anthem.com.

Covered Prescription Drug Benefits

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs are covered when obtained through an eligible pharmacy.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copay. Contact Anthem to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Injectables.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Non-Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other non Covered Services)

- Prescription Drugs dispensed by any Mail Service program other than the Administrator's Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by the Administrator or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.

- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by the Plan, or which exceed any age limits established by the Plan.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services.
- Drugs in quantities which exceed the limits established by the Plan.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onychomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact the Administrator for additional information on these Drugs.
- Refills of lost or stolen medications.

Deductible and Coinsurance

Each Prescription Order is subject to the Deductible and, after the deductible is met, to coinsurance; however, the deductible is waived for certain preventive prescriptions. Preventive prescriptions that are not subject to the deductible can be found at www.hr.iu.edu/benefits/2011/hdhp-rx.pdf. The Prescription Drug Coinsurance will be the lesser of the scheduled Coinsurance amount or the Maximum Allowable Amount. See the Schedule of Benefits for any applicable Deductible and Coinsurance. If a Member receives Covered Services for a Non-Network Pharmacy, a Deductible and Coinsurance amount may also apply.

Tiers

HDHP plans do not recognize tiers of drugs (generic, formulary brand, non-formulary brand) for purposes of determining copays because the Member's share of prescription costs is based on a percent coinsurance.

Days Supply

The number of days supply of a Drug is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If going on vacation and need more than the days supply

allowed for under this Benefit Booklet, ask a Pharmacist to call the PBM and request an override for one additional refill. This will allow a Member to fill their next prescription early. If more than one extra refill is required, please call the Customer Service telephone number on the back of your Identification Card.

Preventive Prescription Benefit

The HDHP PPO & Health Savings Account includes the Preventive Prescription benefit. This benefit requires lower Copays, and waives Deductibles, on certain Prescription Drugs which are summarized in the Anthem Preventive Prescription Drug List. This list is a combination of drugs that have been identified as useful in preventing disease or illness. A copy of this list can be obtained at www.hr.iu.edu/benefits/2011/hdhp-rx.pdf. This list is subject to periodic review and amendment.

Special Programs

From time to time Anthem may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Mail Service Drugs, over the counter, or preferred products. Such programs may involve reducing or waiving Copays for certain Drugs or preferred products for a limited period of time.

Half-Tablet Program

The Half-Tablet Program will allow Members to pay a reduced Copay on selected “once daily dosage” medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take “1/2 tablet daily” of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member’s decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact Anthem at the number on the back of your ID Card.

Payment of Benefits

The amount of benefits paid is based upon whether the Covered Services received are from a Network Pharmacy, including a Network Specialty Pharmacy, a Non-Network Pharmacy, or the Anthem Mail Service Program. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply. The amounts for which Members are responsible is shown in the Schedule of Benefits. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Copay for which the Member is responsible.

How to Obtain Prescription Drug Benefits

Network Pharmacy – Present the written Prescription Order from a Physician and Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file the claim for the Member. Members will be charged at the point of purchase for applicable Deductible and/or Copay amounts. If the Identification Card is not presented, Members will have to pay the full retail price of the prescription. If the full charge is paid by the Member, ask the pharmacist for an itemized receipt and submit it to Anthem with a written request for refund.

Specialty Drugs – Specialty Drugs can be ordered by Members and/or their Physician directly from PrecisionRx Specialty Solutions OR a Specialty Network Pharmacy, by calling 1-800-870-6419. If Specialty Drugs are ordered from PrecisionRx Specialty Solutions the Member will be assigned a patient care coordinator who will work with the Member and their Physician to obtain Prior Authorization and to coordinate the shipping of Specialty Drugs directly to the Member or their Physician’s office. The patient care coordinator will also contact Members directly when it is time to refill their Specialty Drug Prescription.

Non-Network Pharmacy – Members are responsible for payment of the entire amount charged by a Non-Network Pharmacy. A Prescription Drug claim form must be submitted to the Plan for reimbursement consideration. These forms are available from Anthem and/or Indiana University. Members must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, an itemized receipt must be attached to the claim form and submitted to the Plan.

The itemized receipt must show:

- name and address of the Non-Network Pharmacy;
- patient's name;
- prescription number;
- date the prescription was filled;
- name of the Drug;
- cost of the prescription;
- quantity of each covered Drug or refill dispensed.

Members are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by Anthem or the PBM's normal or average contracted rate with Network pharmacies on or near the date of service.

Anthem Mail Service – Complete the Order and Patient Profile Form. Members will need to complete the patient profile information only once. Written prescriptions from a Physician may be mailed, or the Physician may fax the prescription to the Mail Service. Physicians may also phone in the prescription to the Mail Service Pharmacy. Members will need to submit the applicable Deductible and/or Copay amounts to the Mail Service when a prescription or refill is requested.

Section D — Non-Covered Services/Exclusions

The Plan does not provide benefits for procedures, equipment, services, supplies or charges:

1. Which Anthem, on behalf of Indiana University, determines are not Medically Necessary or do not meet the Anthem's medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet, or recognized by the Plan.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Anthem, on behalf of Indiana University. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if the Administrator deems it to be Experimental/Investigative.
4. For any condition, disease, defect, ailment, 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. If Worker's Compensation Act benefits are not available, then this Exclusion does not apply. This exclusion applies if benefits are received in whole or in part. This exclusion also applies whether or not the benefits or compensation are claimed. It also applies whether or not a Member recovers from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
9. For court ordered testing or care unless Medically Necessary.
10. For which Members have no legal obligation to pay in the absence of this or like coverage.
11. For the following:
 - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
 - Surcharges for furnishing and/or receiving medical records and reports.
 - Charges for doing research with Providers not directly responsible for your care.
 - Charges that are not documented in Provider records.
 - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
 - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
12. Received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.
13. Prescribed, ordered or referred by or received from a Member of a Member's immediate family, including their spouse, child, brother, sister, parent, in-law, or self.
14. For completion of claim forms or charges for medical records or reports unless otherwise required by law.

15. For missed or canceled appointments.
16. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Anthem, on behalf of the Plan, or specifically stated as a Covered Service.
17. For 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 Benefit Booklet 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, Anthem will calculate benefits as if they had enrolled.
18. Charges in excess of the Plan's Maximum Allowable Amounts.
19. Incurred prior to a Member's Effective Date.
20. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
21. For any procedures, services, equipment or supplies provided in connection with cosmetic services.
22. Cosmetic services are primarily intended to preserve, change or improve appearances or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of the skin or to change the size, shape or appearance of facial or body features (such as nose, eyes, ears, cheeks, chin, chest or breasts).
23. Complications directly related to cosmetic services treatment or surgery, as determined by Anthem, on behalf of the Plan, is not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
24. Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
25. For the following:
 - Custodial Care, convalescent care or rest cures.
 - Domiciliary care provided in a residential institution, treatment center, supervised living or halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - Care provided or billed by residential treatment centers or facilities, unless those centers or facilities are required to be covered under state law. This includes but is not limited to individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
 - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, halfway house, or outward bound programs, even if psychotherapy is included.
 - Wilderness camps.
26. For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
 - a. cleaning and soaking the feet.

- b. applying skin creams in order to maintain skin tone.
 - c. other services that are performed when there is not a localized illness, injury or symptom involving the foot.
27. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
28. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Benefit Booklet. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
- a. extraction, restoration and replacement of teeth.
 - b. medical or surgical treatments of dental conditions.
 - c. services to improve dental clinical outcomes.
29. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
30. For Dental implants.
31. For Dental braces.
32. For Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
- a. transplant preparation.
 - b. initiation of immunosuppressives.
 - c. Direct treatment of acute traumatic injury, cancer or cleft palate.
33. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
34. Weight loss programs or prescription drugs whether or not they are under medical or Physician supervision except as specifically listed as covered in the “Covered Services” section. Weight loss programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity.
35. For marital counseling.
36. 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, or for soft contact lenses due to a medical condition.
37. For vision orthoptic training.
38. For hearing aids or examinations for prescribing or fitting them.
39. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
40. For services to reverse voluntarily induced sterility.
41. For diagnostic testing or treatment related to infertility.
42. For personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals; charges for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as water purifiers; allergenic pillows, cervical neck pillows, special mattresses, or waterbeds; infant helmets to treat positional plagiocephaly; safety helmets for Members with neuromuscular diseases; or sports helmets.

43. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
44. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by Anthem, on behalf of the Plan.
45. For care received in an Emergency room which is not Emergency Care, except as specified in this Benefit Booklet. This includes, but is not limited to suture removal in an Emergency room.
46. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.
47. For expenses incurred at a health spa or similar facility.
48. For self-help training and other forms of non-medical self care, except as otherwise provided herein.
49. For examinations relating to research screenings.
50. For stand-by charges of a Physician.
49. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, travel, or for other purposes.
50. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
51. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the “Covered Services” section.
52. For Manipulation Therapy Services rendered in the home as part of Home Care Services.
53. Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
54. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
55. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergiel synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
56. For any services or supplies provided to a person not covered under the Benefit Booklet in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
57. For surgical treatment of gynecomastia.

58. For treatment of hyperhidrosis (excessive sweating).
59. For any service for which a Member is responsible under the terms of this Benefit Booklet to pay a Copay or Deductible, and the Copay or Deductible is waived by a Non-Network Provider.
60. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Anthem, on behalf of the Plan, through Prior Authorization.
61. Complications directly related to a service or treatment that is a Non-Covered Service under the Plan because it was determined by Anthem, 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.
62. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
63. 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.
64. Treatment of telangiectatic dermal veins (spider veins) by any method.
65. Reconstructive services except as specifically stated in the Covered Services section of this Benefit Booklet, or as required by law.
66. Nutritional and/or dietary supplements, except as provided in this Benefit Booklet or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
67. Drugs not on the Covered Prescription Drug List. Non-sedating or third generation antihistamines are not on the Covered Prescription Drug List.
68. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
69. For room and board charges unless the treatment provided meets the Administrator's Medical Necessity criteria for Inpatient admission for the Member's condition.
70. For services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.

Experimental/Investigative Exclusions

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem, on behalf of the Plan, determines in its sole discretion to be Experimental/Investigative is not covered under the Plan. Anthem, on behalf of the Plan, will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if Anthem, on behalf of the Plan, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Anthem, on behalf of the Plan. In determining whether a Service is Experimental/Investigative, Anthem, on behalf of the Plan, will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Anthem, on behalf of the Plan to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

Anthem, on behalf of the Plan, has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Section E — How to Obtain Covered Services

Network Providers are the key to providing and coordinating health care services. Benefits are provided when Covered Services are obtained from Providers; however, the broadest benefits are provided for services obtained from a Network Provider. **Services obtained from any Provider other than a Network Provider are considered a Non-Network Service, except for Emergency Care, Urgent Care, or as an Authorized Service.** Contact a Network Provider, or Anthem, to be sure that Prior Authorization and/or precertification has been obtained.

If a Non-Network Provider meets Anthem's enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network Provider for the Network associated with the Plan.

Network Services and Benefits

If care is rendered by a Network Provider, benefits will be paid at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a Network Provider. All medical care must be under the direction of Physicians. Anthem, on behalf of the Plan, has final authority to determine the Medical Necessity of the service.

Anthem, on behalf of the Plan, may inform Members that it is not Medically Necessary to receive services or remain in a Hospital or other facility. This decision is made upon review of the condition and treatment. This decision may be Appealed. See the Member Grievances section of this Benefit Booklet.

Network Providers—include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with Anthem to perform services. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians, or other Network Providers as allowed by the Plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange health care services. SCP's are Network Physician who provide specialty medical services not normally provided by a PCP.

For services rendered by Network Providers:

1. Members are not required to file any claims for services obtained directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from the Plan and not from the Member except for approved Copay and/or Deductibles. Members may be billed by their Network Provider(s) for any non-Covered Services received or when a Member not acted in accordance with the Plan.
2. Health Care Management is the responsibility of the Network Provider. If there is no Network Provider who is qualified to perform the treatment required, contact Anthem prior to receiving the service or treatment and Anthem may approve a Non-Network Provider for that service as an Authorized Service.

Non-Network Services

Services which are not obtained from a Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exception is Emergency Care. Hospice and Ambulance Services have the same In-Network Member Copay, however, the Member is responsible for amounts above the Network charges.

In addition, certain services are not covered unless obtained from a Network Provider; see the Schedule of Benefits.

For services rendered by a Non-Network Provider, Members are responsible for:

- The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Copay;
- Services that are not Medically Necessary;
- Non-Covered Services;
- Higher cost sharing amounts.

Relationship of Parties (Plan - Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

The Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. For any questions regarding such incentives or risk sharing relationships, contact the Provider or the Plan.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care received from any person. The Plan does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies.

Identification Card

When care is received, Members must show their Identification Card. Only a Member who has paid the Premiums under the Plan has the right to services or benefits under the Plan. If anyone receives services or benefits to which they are not entitled to under the terms of this Benefit Booklet, he/she is responsible for the actual cost of the services or benefits.

Section F — Claims Payment

When care is received through a Network Provider, Members are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim. A claim must be filed for a Member to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit claims for the Member.

HOW BENEFITS ARE PAID

Maximum Allowable Amount

The amount that Anthem, on behalf of the Plan, or Anthem's Subcontractor, determines is the maximum payable for Covered Services received. Generally, to determine the Maximum Allowable Amount for a Covered Service, Anthem or Anthem's Subcontractor use, in addition to other information, internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service or supply.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement for this product, the lesser amount will be the Maximum Allowable Amount. For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with Anthem for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

For a Non-Network Provider which is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services under this product or any other product. In the absence of a negotiated amount, Anthem, on behalf of the Plan, shall have discretionary authority to establish as they deem appropriate, the Maximum Allowable Amount. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility's charge, or an amount determined by Anthem, after consideration of any one or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that Anthem may have made, or other factors Anthem, on behalf of the Plan, deems appropriate.

It is the Member's obligation to pay any Copay and Deductibles, and any amounts which exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its participation agreement with Anthem, on behalf of the Plan.

Member Responsibility

What a Member pays often depends on the type of service received and if a Network or Non-Network Provider is used. Refer to the "Schedule of Benefits" section of this Benefit Booklet to see what amounts are required to be paid for each Covered Service. This Plan shares the cost of medical expenses with Members up to a pre-determined amount, or the Maximum Allowable Amount. The Plan will not pay any portion of any charge that exceeds this amount.

Services may be subject to a Copay and/or Deductible, as outlined in the Schedule of Benefits. Deductibles will be based on the Maximum Allowable Amount. Copay is the Member's share of the cost for Covered Services, and generally must be paid at the time the Covered Services are received. The Plan pays the share of the balance up to the Maximum Allowed Amount.

Network Providers will seek payment from the Plan for Covered Services for the Maximum Allowable Amount, and will accept this amount as full payment.

If Members receive Covered Services from a Non-Network Provider, the Member is responsible for the difference between the actual amount billed and the Maximum Allowable Amount, plus any Deductible, Copay, and charges for non-Covered Services. However, these guidelines change when Covered Services are received in a Network Provider facility, but from a Non-Network Provider. If Covered Services are received in a Network Provider facility from a Non-Network Provider such as an anesthesiologist who is employed by or contracted with that Network Facility, benefits will be paid. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full under a Network Provider's participation agreement for this product. Members may be liable for the difference between the billed charge and the Plan's Maximum Allowable Amount. This does not apply if the treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The Plan will not pay any portion of any charge that exceeds the Maximum Allowable Amount.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowable Amount. If services are performed by Non-Network Providers, then the Member is responsible for any amounts charged in excess of the Plan's Maximum Allowable Amount with or without a referral or regardless if allowed as an Authorized Service. Contact Anthem for more information.

PAYMENT OF BENEFITS

Members authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under Indiana University's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan's obligation to pay for Covered Services. Members cannot assign the right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law. Once a Provider performs a Covered Service, the Plan will not honor a request to withhold payment of the claims submitted.

NOTICE OF CLAIM

The Plan is not liable unless Anthem receives written notice that Covered Services have been given to a Member. The notice must be given to Anthem, on behalf of the Plan, within 90 days of receiving the Covered Services, and must have the data Anthem needs to determine benefits. If the notice submitted does not include sufficient data needed to process the claim, then the necessary data must be submitted to Anthem within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If Anthem has not received the information it needs to process a claim, they will ask for the additional information necessary to complete the claim. Generally, the Member will receive a copy of that request for additional information, for informational purposes. In those cases, Anthem cannot complete the processing of the claim until the additional information requested has been received. Anthem, on behalf of the Plan, generally will make its request for additional information within 30 days of their initial receipt of the claim and will complete the processing of the claim within 15 days after receipt of all requested information. An expense is considered incurred on the date the service or supply was given. **If Anthem is unable to complete processing of a claim because a Member or their Provider fails to provide Anthem with the additional information within 60 days of its request, the claim will be denied and the Member will be financially responsible for the claim.**

Failure to give Anthem notice within 90 days will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim, can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

TIME BENEFITS PAYABLE

The Plan will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. At the Plan's discretion, benefits will be paid to the Member or Provider of services. Members may not assign any payment. If other parties have paid benefits under this Plan, the Plan may reimburse those other parties and be fully discharged from that portion of its liability.

CLAIM FORMS

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to Anthem or contact customer service and ask for claim forms to be sent. Claim forms are also available on the University Human Resources services Web site at www.hr.iu.edu.

If claim forms are not received, written notice of services rendered may be submitted to Anthem without the claim form. The same information that would be given on the claim form must be included in the written notice of claim.

This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type and place of service.
- The Member's signature and the Provider's signature.

MEMBER'S COOPERATION

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare,

Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

EXPLANATION OF BENEFITS (EOB)

After Members receive medical care, they will generally receive an explanation of benefits (EOB). The EOB is a summary of the coverage received. The EOB is not a bill, but a statement from the Plan to help Members understand the coverage they are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by a Member's coverage.
- The amount for which the Member responsible (if any).
- General information about Appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

BLUECARD PROGRAM

When health care services are obtained through the BlueCard Program outside the geographic area Anthem serves, the amount a Member pays for Covered Services is calculated on the lower of:

- The billed charges for the Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto Anthem, on behalf of the Plan.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the Member's health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with the Member's health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices. However, the amount a Member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, Anthem, on behalf of the Plan, would then calculate Member liability for any Covered Services in accordance with the applicable state statute in effect at the time care was received.

Members are entitled to benefits for health care services received either inside or outside the geographic area Anthem serves if the Plan covers those health care services. Due to variations in Host Blue medical practice protocols, Members may also be entitled to benefits for some health care services obtained outside the geographic area Anthem serves, even though a Member might not otherwise have been entitled to benefits if they had received those health care services inside the geographic area Anthem serves. But in no event will a Member be entitled to benefits for health care services, wherever received, that are specifically excluded or limited from coverage by the Plan.

If services are obtained in a state with more than one Blue Plan Network, an exclusive Network arrangement may be in place. If a Member sees a Provider who is not part of an exclusive Network arrangement, that Provider's service(s) will be considered Non-Network care and the Member may be billed the difference between the charge and the Maximum Allowable Amount. Call the Customer Service number on the ID Card or go to www.anthem.com for more information about such arrangements.

Section G — Health Care Management

HEALTH CARE MANAGEMENT

Health Care Management includes the processes of Precertification, Predetermination and Medical Review. Its purpose is to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources and optimizing the health of the Members. These processes are described in the following section. Any questions regarding the information contained in this section may be directed to the Precertification telephone number on the back of the Identification Card or by visiting www.anthem.com.

Types of Requests

Precertification—A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For Emergency admissions, the Member, authorized representative, or Physician must notify Anthem within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination—An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. Anthem will review the Benefit Booklet to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Benefit Booklet or is Experimental/Investigative as that term is defined in this Benefit Booklet.

Medical Review—A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment, or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which Anthem has a related clinical coverage guideline and are typically initiated by Anthem.

Who is Responsible for Precertification

Services Provided by a Network Provider	Services Provided by a Non-Network Provider
Provider is responsible for Precertification.	Member is responsible for Precertification. Member is financially responsible for service and/or setting that are/is not covered under the Plan based on an Adverse Determination of Medical Necessity or Experimental/ Investigative.

Most Network Providers know which services require Precertification and will obtain any required Precertification or request a Predetermination if they feel it is necessary. Primary Care Physicians and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met.

The ordering Provider, facility or attending Physician will contact Anthem to request a Precertification or Predetermination review (“requesting Provider”). Anthem will work directly with the requesting Provider for the Precertification request. However, the Member may designate an authorized representative to act on their

behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Anthem will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventative care clinical coverage guidelines, to assist in making Medical Necessity decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. Anthem reserves the right to review and update these clinical coverage guidelines periodically. This Benefit Booklet and the Administrative Services Agreement take precedence over these guidelines.

Members are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to their request. To request this information, contact the Precertification telephone number on the back of the Identification Card.

Request Categories

Urgent—a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member’s medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.

Prospective—a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.

Concurrent—a request for Precertification or Predetermination that is conducted during the course of treatment or admission.

Retrospective—a request for Precertification that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, Anthem will abide by state regulations. Members may call the telephone number on the back of their Membership card for additional information.

Request Category	Timeframe Requirement for Decision/Notification
Precertification Requests	
Prospective Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	2 business days from the receipt of the request
Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request

Request Category	Timeframe Requirement for Decision/Notification
Precertification Requests	
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours or 2 business days from the receipt of request whichever is less
Concurrent Non-Urgent	2 business days from the receipt of the request Retrospective 2 business days from the receipt of the request
Predetermination Requests	
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent Non-Urgent	15 calendar days from the receipt of the request

If additional information is needed to make Anthem’s decision, they will notify the requesting Provider and send written notification to the Member or their authorized representative of the specific information necessary to complete the review. If Anthem does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in Anthem’s possession.

Anthem will provide notification of its decision in accordance with state and federal regulations. Notification may be given by the following methods:

Verbal—oral notification given to the requesting Provider via telephone or via electronic means if agreed to by the Provider.

Written—mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and the Member or authorized Member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date services are received:

1. The Member must be eligible for benefits;
2. Premiums must be paid for the time period that services are rendered;
3. The service or surgery must be a covered benefit under the Plan;
4. The service cannot be subject to an exclusion under the Plan, including but not limited to a Pre-Existing Condition limitation or exclusion; and
5. The Member must not have exceeded any applicable limits under the Plan.

Care Management

Care Management is a Health Care Management feature designed to help promote the timely coordination of services for Members with health-care related needs due to serious, complex, and/or chronic medical conditions. Anthem's Care Management programs coordinate health care benefits and available services to help meet health-related needs of Members who are invited and agree to participate in the Care Management Program. Anthem's Care Management programs are confidential and voluntary. These programs are provided at no additional cost to the Subscriber and do not affect Covered Services in any way. Licensed health care professionals trained in care management and familiar with the benefit plan provide these services.

For Members who meet program requirements/criteria and who agree to participate in a Care Management program, a licensed health care professional completes an assessment and develops an individualized plan designed to help meet their identified health care related needs. This is achieved through communication, and collaboration with the Member and/or Member's designated representative, treating Physician(s), and other Providers. The licensed health care professional remains in contact with the Member by telephone on a periodic basis to help accomplish the goals of the plan. In addition to coordinating benefits, the licensed health care professional may assist with coordination of care with existing community-based programs and services to meet the Member's needs. Care coordination may include referrals to external agencies and available community-based programs and services.

Value-Added Programs

Anthem may offer health or fitness related programs to the Plan's Members, through which Members may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under the Plan and could be discontinued at any time. Anthem does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services received.

Section D - Non-Covered Services/Exclusions indicates items which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

Section H — Member Grievances

If a Member is dissatisfied with medical treatment they have received, it should be discussed with the Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, the Plan should be contacted by the Member, either orally or in writing, to obtain information on the Plan's Grievance procedures or to file a Grievance with the Plan.

Members have the right to designate a representative (e.g. a Physician) to file a Grievance and, if the Grievance decision is adverse to the Member, an Appeal, with the Plan on the Member's behalf and to represent the Member in a Grievance or an Appeal. If a Provider files a Grievance with the Plan that qualifies for Expedited Review, the Provider will be deemed to be the Member's representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on a Member's behalf, Anthem must obtain a signed Designation of Representation form from the Member before they can deal directly with the representative. Anthem will forward a Designation of Representation form to the Member for completion. If Anthem does not obtain a signed Designation of Representation form, they will continue to research the Grievance but will respond only to the Member unless a signed Designation of Representation form is received.

Anthem will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on the Plan's Grievance procedures or to file a Grievance orally with the Plan, call the toll free customer service number listed on the back of the Plan Identification Card. A Plan representative who is knowledgeable about the Plan's Grievance procedures and any applicable state laws and regulations will be available to assist Members at least 40 normal business hours per week. Members can also call Anthem at 1-800-345-2460 at any time to leave a voice mail message concerning a Grievance. Any messages left through this toll-free number will be returned on the following business day by a qualified Plan representative. Anthem will also accept Grievances filed in writing, including by facsimile. If Members wish to file a Grievance in writing, it should be mailed to: Anthem Appeals, P.O. Box 33200, Louisville KY 40232-3200, ATTN: Appeals Specialist. Anthem's facsimile number is 1-317-287-5968 if Members wish to file their Grievance by fax.

Upon the Plan's receipt of a Member's written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing Appeals on any adverse decision notice received from Anthem), an acknowledgment will be sent to the Member within 5 business days notifying the Member that they will receive a written response to the Grievance once an investigation into the matter is complete. The Plan's acknowledgment may be oral for those Grievances Anthem receives orally. All Grievances will be resolved by Anthem within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing Appeals on any adverse decision notice received from Anthem).

If a Member's Grievance cannot be resolved within 20 business days due to the Plan's need for additional information and the Grievance does not relate to an adverse certification decision (i.e., Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, the Member will be notified in writing of a 10 business day extension. This notice for an extension will be sent to the Member on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from a Member, and such information has not been received within 15 business days from the Plan's original request. In the event of an extension, Anthem, on behalf of the Plan, will resolve the

Grievance within 30 business days from the date the Grievance was filed. If the requested information has not been received, Anthem will make a determination based on the information in the Plan's possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member. Within 5 business days after the Grievance is resolved, Anthem will send a letter to the Member notifying them of the decision reached.

Appeals

If the Plan's decision under the Grievance process is satisfactory, the matter is concluded. If the Plan's decision is not satisfactory, the Member or their designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers.

The Member will receive an acknowledgment of the Appeal within 5 business days of the Plan's receipt of the Appeal request. The Plan's acknowledgment may be oral for those Appeals Anthem receives orally. Anthem will set a date and time during normal business hours for the Plan's Appeal panel Members to meet to discuss the Appeal. The Member or their representative do not have to be present when the panel meets; however the Member and/or their representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. The Member or their representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not the Subscriber chooses to appear in person or by telephone. Members will be given at least 72 hours advance notice of the date and time of the panel meeting, unless the Appeal qualifies for Expedited Review.

Appeals concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan will be resolved by the panel no later than 30 calendar days from the date the Appeal request was received by Anthem. The panel will resolve all other Appeals no later than 45 business days from the date the Appeal request was received by Anthem. After the Appeal panel makes a decision, the Member will be notified within 5 business days in writing by Anthem of the Plan's decision concerning the Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to the Member or Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- The Member's Physician believes that the standard Appeal time frames could seriously jeopardize the life or health of the Member, or could subject them to severe pain that cannot be adequately managed.

Anthem will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of the Plan's receipt of sufficient information and will communicate the Plan's decision by telephone to the Member's attending Physician or the ordering Provider. Anthem will also provide written notice of the Plan's determination to the Member, their attending Physician or ordering Provider, and the facility rendering the service.

Anthem will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. The Plan's decision will be communicated by telephone to the attending Physician

or the ordering Provider. Anthem will also provide written notice of the Plan's determination to the Member, their attending Physician or ordering Provider, and to the facility rendering the service.

External Grievance

If the Plan's decision under the Appeals process is not satisfactory, Members may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

- The Appeal is regarding:
 1. an adverse determination of appropriateness; or
 2. an adverse determination of Medical Necessity; or
 3. a determination that a proposed service is Experimental/Investigational made by Anthem or an agent of Anthem's regarding a service proposed by the treating Physician; and
- The Member or their representative requests the External Grievance in writing within forty-five (45) days after the Subscriber is notified of the Appeal panel's decision concerning the Appeal; and
- The service is not specifically excluded in this Benefit Booklet.

If an External Grievance is requested, Anthem will forward the Grievance along with all relevant information to an Independent review organization. The Independent review organization will make a determination to uphold or reverse the Plan's Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The Independent review organization will notify the Member and Anthem of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the Independent review organization's determination is to reverse the Plan's Appeals decision, Anthem will notify the Member or their Provider in writing of the steps Anthem will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

The Plan expects that Members will use good faith to file a Grievance or an Appeal on a timely basis. However, Anthem will not review a Grievance if it is received by them after the end of the calendar year, and 12 months have passed since the incident leading to the Grievance. Anthem will accept Appeals filed within 60 days after the Member is notified of the Plan's decision concerning their Grievance. Anthem will accept External Grievance requests filed within 45 days after the Member is notified of the Plan's Appeal decision.

Grievances and Appeals by Members of ERISA Plans

If covered under an Employer plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), Members must file a Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while an Appeal is pending. The Member will be notified of their right to file a voluntary Appeal if the Plan's response to the Grievance is adverse. Upon request, Anthem will also provide Members with detailed information concerning an Appeal, including how panelists are selected.

Section I — Other Provisions

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire agreement between the Plan and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Employer and any and all statements made to the Employer by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or employee of Anthem is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by a person authorized to sign on behalf of the Employer.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that they, in consultation with their Providers, are responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment recommended by your Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. In this event, the Provider shall have no further responsibility to provide care to you, and the Plan shall have no obligation to have Network Providers available who will render the care.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Plan, disability affecting a significant number of a Network Provider's staff or similar causes, or health care services provided under the Plan are delayed or considered impractical. Under such circumstances, the Plan and Network Providers will provide the health care services covered by the Plan as far as is practical under the circumstances, and according to their best judgment. However, the Plan and Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of the Plan.

PROTECTED HEALTH INFORMATION UNDER HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations

issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As an Administrator of your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the customer service number on the back of your Identification Card.

SUBROGATION AND REIMBURSEMENT

Subrogation

The Plan has the right to recover payments it makes on a Member's behalf from any party responsible for compensating Members for their injuries. The following apply:

- The Plan has first priority for the full amount of benefits it has paid from any Recovery regardless of whether the Member is fully compensated, and regardless of whether the payments received make the Member whole for their losses and injuries.
- Members and their legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice them.
- The Plan has the right to take whatever legal action it sees fit against any party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim still held, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to the Member's claim, attorney fees, or other expenses or costs.
- The Plan is not responsible for any attorney fees, other expenses or costs incurred without the Plan's prior written consent. The Plan further agrees that the "common fund" doctrine does not apply to any funds recovered by any attorney hired regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If a Recovery is obtained and the Plan has not been repaid for the benefits the Plan paid on the Member's behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid, and the following apply:

- The Plan must be reimbursed to the extent of benefits the Plan paid on the Member's behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Plan shall have a right of Recovery, in first priority, against any Recovery.
- The Member and any legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon receipt of the Recovery. The Plan must be reimbursed, in first priority and without

any set-off or reduction for attorney fees, other expenses, or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If a Member fails to repay the Plan, it shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of the Recovery, whichever is less, from any future benefit under the Plan if:
 1. The amount the Plan paid on the Member’s behalf is not repaid or otherwise recovered by the Plan;
 2. The Member’s failure to cooperate.
- In the event of failure to disclose to the Plan the amount of the settlement, the Plan shall be entitled to deduct the amount of the Plan’s lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of the settlement, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be the Member’s obligation to pay the Provider the full billed amount, and the Plan would not have any obligation to pay the Provider.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make the Member whole.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from the Member or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown on the Explanation of Benefits (EOB) is the final determination and notice of an adjusted cost share amount will not be sent as a result of such Recovery activity.

Anthem, on behalf of the Plan, may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. Anthem has established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. Anthem will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. Anthem, on behalf of the Plan, may not provide Members with notice of overpayments made by the Plan or Members if the Recovery method makes providing such notice administratively burdensome.

Member Duties

- Notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness occurred and all information regarding the parties involved.
- Cooperate with the Plan in the investigation, settlement and protection of the Plan’s rights.
- Send the Plan copies of all police reports, notices or other papers received in connection with the accident

- or incident resulting in personal injury or illness.
- Promptly notify the Plan of any retention of an attorney or if a lawsuit is filed on the Member's behalf.

RELATIONSHIP OF PARTIES (EMPLOYER-MEMBER PLAN)

Neither the Employer nor any Member is the agent or representative of the Plan. The Employer is responsible for passing information to the Member. For example, if the Plan gives notice to the Employer, it is the Employer's responsibility to pass that information to the Member. The Employer is also responsible for passing eligibility data to the Plan in a timely manner. If the Employer does not provide the Plan with timely enrollment and termination information, the Plan is not responsible for the payment of Covered Services for Members.

CONFORMITY WITH LAW

Any provision of this Plan which is in conflict with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

CLERICAL ERROR

A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or the Plan.

WAIVER

No agent or other person, except an authorized officer of the Plan, is able to disregard any conditions or restrictions contained in this Benefit Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

RESERVATION OF DISCRETIONARY AUTHORITY

Anthem shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Grievances and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. Anthem's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowable Amount. A Member may utilize all applicable Member Grievance procedures.

POLICIES AND PROCEDURES

Indiana University is able to introduce new policies, procedures, rules and interpretations, as long as they are

reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules and interpretations.

Under the terms of the Administrative Services Agreement, Anthem has the authority, in its sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Benefit Booklet. Anthem reserves the right to discontinue a pilot or test program at any time. Anthem will provide advance written notice to Indiana University of the introduction or termination of any such program.

Indiana University's Sole Discretion

Indiana University may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if Indiana University, with advice from Anthem, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

RELEASE OF MEDICAL RECORDS AND INFORMATION

In order to administer the benefits described in this Benefit 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's Web site; from the Health Care Data Administrator; in Section I (HIPAA Notice of Privacy Practices) of 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;
- 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;
- 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;
- Report to the plan's designee any use of information that it becomes aware is inconsistent with permitted uses;
- Make such information available to an individual for review or amendment and provide an accounting of disclosures as required by HIPAA;
- Cooperate with the Secretary of the U.S. Department of Health and Human Services as needed to determine the plan's compliance with HIPAA;
- 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. This medical plan consists of various components, that is, medical, mental health and chemical dependency, prescription drug, and transplant benefits. 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 personal health information for the purposes of treatment, payment, and to carry out medical 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 medical plan also uses and discloses personal health information as required by law and government oversight agencies.

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

Health 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 health 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.

Section J — Definitions

If a word or phrase in this Benefit Booklet have special meaning, or is a title, it will start with a capital letter. If the word or phrase is not explained in the text where it appears, it will be defined in this section. For additional clarification on any of these definitions, please contact the customer service number located on the back of the ID Card or submit questions online at www.anthem.com.

Actively At Work – An employee who is capable of carrying out their regular job duties and who is present at their place of work. Additionally, Subscribers who are absent from work due to a health related absence or disability and those on maternity leave or scheduled vacation, are considered Actively At Work.

Administrator – An organization or entity that Indiana University contracts with to provide administrative and claims payment services under the Plan. The Administrator for this Plan is Anthem Insurance Companies, Inc. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem Independent Laboratory Network – The Network of laboratories with whom Anthem has contracted to provide cost effective laboratory services to its Members. These include Quest Diagnostics and STAT Lab LLC. For a full listing of Anthem Independent Laboratories, please visit www.anthem.com.

Appeal – A formal request by a Member or their representative for reconsideration of a decision not resolved to satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff Members of the Plan who did not previously render an opinion on the resolution of the Grievance.

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 Anthem, on behalf of the Plan, to be paid at the Network level.

Behavioral Health Conditions –

- *Mental Health Condition* – A display of mental or nervous symptoms that are not a result of any physical or biological cause(s) or disorder(s).
- *Substance Abuse* - A condition that develops when an individual uses alcohol or other drug(s) in a way that damages their health and/or causes them to lose control of their actions.

Behavioral Health Services Subcontractor – An organization or entity that the Plan has a contract with to provide administrative and claims payment services and/or Covered Services regarding Behavioral Health services under the Plan. These administrative services are provided by Anthem Behavioral Health.

Benefit Booklet – This summary of the terms of health benefits under this Plan.

Brand Name Drug – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer’s own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

Copay – A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which the Member must pay. Copay normally applies after the Deductible that Members are required to pay. See the Schedule of Benefits for any exceptions.

Covered Prescription Drug List – A list (also known as a formulary) of drugs covered under the prescription benefit of this Plan. Drugs not on the list are not covered.

Covered Services – Services, supplies or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under the Plan.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance by Anthem, on behalf of the Plan, if such Prior Authorization is required in this Benefit Booklet.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission except as otherwise specified in benefits after termination. Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Anthem, on behalf of the Plan, including necessary acquisition costs and preparatory myeloblastic therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any Diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Custodial Care – Care primarily for the purpose of assisting a Member in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which a Member must pay for before the Plan will pay for those Covered Services in each Plan Year.

Dependent – A Member of the Subscriber’s family who is covered under the Plan. Dependents must be added within 30 days of acquiring legal Dependent status by contacting a Human Resources office.

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.

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.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date that a Subscriber’s coverage begins under the Plan. The Subscriber must be Actively At Work on the Effective Date for coverage to begin. If not Actively At Work on the Effective Date, the Effective Date changes to the date that the Subscriber does become Actively At Work. A Dependent’s coverage also begins on the Subscriber’s Effective Date.

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

Emergency – An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual’s health in serious jeopardy;
- result in serious impairment to the individual’s bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care – Covered Services that are furnished by a Provider within the scope of the Provider’s license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

Employer – Indiana University. The legal entity contracting with Anthem for administration of group health care benefits.

Expedited Review – The expedited handling of a Grievance or Appeal concerning the Plan’s denial of certification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when a Member’s health condition is an Emergency or when time frames for non-Expedited Review could seriously jeopardize the life, health, or ability to regain maximum function of the Member or would subject the Member to severe pain that cannot be adequately managed.

Experimental/Investigative –

1. Any drug, device, Diagnostic, product, equipment, procedure, treatment, or supply for which the Plan Administrator or Plan Administrator’s designee determine, on behalf of the Plan Sponsor, that one or more

of the criteria listed below in this section 1 apply to the service when it is rendered for the evaluation or treatment of a disease, injury, illness or condition. The criteria must apply to the service at the time the Member receives or will receive the service, and must apply to the medical use for which benefits are sought. The service:

- a. Cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted; or
 - b. Is the subject of a current new drug or device application on file with the FDA; or
 - c. Is provided as part of a Phase I or Phase II clinical trial, is provided as the Experimental or research arm of a Phase III clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service; or
 - d. Is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy among its objectives; or
 - e. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
 - f. Is provided pursuant to informed consent documents that describe the service as investigational or Experimental, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy.
2. Any service not deemed investigational or Experimental based on the criteria in 1 above may still be deemed investigational or Experimental if the Plan Administrator or Plan Administrator's designee determine, on behalf of the Plan Sponsor, that the service meets any of the four criteria below:
- a. The scientific evidence does not permit conclusions concerning the effect of the service on health outcomes; or
 - b. The service does not improve net health outcome by producing beneficial effects that outweigh any harmful effects; or
 - c. The service has not been shown to be as beneficial as any of the established alternative services with evidence demonstrating that the service improves net health outcome as much as, or more than, established alternatives; or
 - d. The service has not been shown to improve net health outcomes under the usual conditions of medical practice outside clinical investigatory settings.
3. Documents relied upon by the Plan Administrator or Plan Administrator's designee to determine, on behalf of the Plan Sponsor, whether services are investigational or Experimental based on the criteria in 1 and 2 above may, at the Plan Administrator's or Plan Administrator designee's discretion, on behalf of the Plan Sponsor, include one or more items from the following list which is not all inclusive:
- a. The Member's medical records;
 - b. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided;
 - c. The published, authoritative, peer-reviewed medical or scientific literature regarding the service as it applies to the Member's condition;
 - d. Any consent document(s) the Member or Member's representative have executed or will be asked to

execute to receive the service;

- e. The relevant documents of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided;
 - f. Any records, regulations, applications or other documents or actions issued by, filed with, or received by the FDA, the Office of Technology Assessment, or other federal or state agencies with similar functions, that the Plan Administrator or Plan Administrator's designee, on behalf of the Plan Sponsor, has in its possession at the time of the review; or
 - g. Opinions and evaluations by national medical associations or committees, consensus panels, or other technology evaluation bodies, such as Blue Cross & Blue Shield Association's Technology Evaluation Center.
4. Services provided solely or primarily to support the administration of an investigational or Experimental service, or those provided to treat anticipated or unanticipated results of an investigational or Experimental service, will also be excluded from coverage. Services that are part of the same plan or evaluation or treatment as an investigational or Experimental service, but which, in the opinion of the Plan Administrator or Plan Administrator's designee, on behalf of the Plan Sponsor, would, in the absence of investigational or Experimental service be otherwise Medically Necessary, may be considered eligible for coverage, subject to all benefit requirements, limitations, and exclusions.
5. The Plan Administrator or its designee, on behalf of the Plan Sponsor, has the sole authority and discretion to determine all questions pertaining to whether a service is investigational or Experimental under this Plan.

External Grievance – A Member's right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to the Member.

Fee(s) – The periodic charges which are required to be paid by the Member and/or Indiana University to maintain benefits under the Plan.

Generic Drugs – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

Grievance – Any expression of dissatisfaction made by a Member or their representative to the Plan or its affiliates in which the Member has the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or Medically Necessary;
- a determination that a proposed service is Experimental/Investigative;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between the Member and the Plan or Indiana University and the Plan.

Identification Card / ID Card – A card issued by the Plan, showing the Member's name, Membership number, and occasionally coverage information.

Independent Laboratory Network – See *Anthem Independent Laboratory Network*.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. This does not apply to a Member who is placed under observation for fewer than 24 hours.

Lifetime Maximum – The maximum dollar amount the Plan will pay for Covered Services during a Member's lifetime. While Prescription Drugs do not accumulate toward the Lifetime Maximum, once the Lifetime Maximum has been reached, no additional benefits for Prescription Drugs will be paid.

Mail Service – The Anthem Prescription Management program which offers a convenient means of obtaining maintenance medications by mail if Members take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service and sent directly to the Member's home.

Maximum Allowable Amount – The maximum amount that the Plan will pay for Covered Services received. For more information, see the “Claims Payment” section.

Medically Necessary/ Medical Necessity – An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by Anthem to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention (“cost effective” does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and does not guarantee payment.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required Fee payment.

Network Provider – A Provider who has entered into a contractual agreement or is being used by Anthem, or another organization, which has an agreement with Anthem, to provide Covered Services and certain administration functions for the Network associated with the Plan.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Anthem to render Specialty Drug Services, or with another organization which has an agreement with Anthem, to provide Specialty Drug services and certain administrative functions for the Specialty Pharmacy Network.

Network Transplant Provider – A Provider that has been designated as a “center of excellence” by Anthem and/or a Provider selected to participate as a Network Transplant Provider by a designee. Such Provider has entered into a Transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions for the transplant Network. A Provider may be a Network Transplant Provider with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use. New FDA Approved Drug Product or Technology *does not* include:

- *New formulations* – a new dosage form or new formulation of an active ingredient already on the market;
- *Already marketed Drug product but new manufacturer* – a product that duplicates another firm’s already marketed Drug product (same active ingredient, formulation, or combination);
- *Already marketed Drug product, but new use* – a new use for a Drug product already marketed by the same or a different firm; or
- *Newly introduced Generic medication* – Generic medications contain the same active ingredient as their counterpart brand-named medications.

Non-Network Provider – A Provider who has not entered into a contractual agreement with Anthem for the Network associated with the Plan. Providers who have not contracted or affiliated with the Plan’s designated Subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers.

Non-Network Transplant Provider – Any Provider that has NOT been designated as a “center of excellence” by Anthem or has not been selected to participate as a Network Transplant Provider by a designee.

Open Enrollment – A period of enrollment designated by Indiana University in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; See Eligibility and Enrollment section for more information.

Out-of-Pocket Maximum – A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Plan Year as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or family, then no additional Deductibles and Copay is required for that person and/or family unless otherwise specified in this Benefit Booklet and/or the Schedule of Benefits.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Pharmacy and Therapeutics (P&T) Committee – A committee consisting of health care professionals, including Nurses, Pharmacists, and Physicians. The purpose of this committee is to assist in determining clinical appropriateness of Drugs; determining the assignments of Drugs; and advising on programs to help improve

care. Such programs may include, but are not limited to, drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

Plan – The group health benefit Plan provided by Indiana University and explained in this Benefit Booklet.

Plan Administrator – See *Administrator*.

Plan Year – A calendar year, i.e., January 1 through December 31. If a Member's coverage ends before the end of the Plan Year, the Plan Year also ends.

Pre-Existing Condition – A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before the Enrollment Date.

Primary Care Physician (“PCP”) – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T Committee.

Provider – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider.

Providers include, but are not limited to, the following persons and facilities listed below. For questions about a Provider not shown below, please call the number on the back of the ID Card.

Alcoholism Treatment Facility – A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

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, with an organized staff of Physicians, that:

1. Is licensed as such, where required;
2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

4. Does not provide Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

Certified Advance Registered Nurse Practitioner

Certified Nurse Midwife

Certified Registered Nurse Anesthetist

Certified Surgical Assistant

Day Hospital – A facility that provides day rehabilitation services on an Outpatient basis.

Dialysis Facility – A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at a Member's home. It is not a Hospital.

Drug Abuse Treatment Facility – A facility which provides detoxification and/or rehabilitation treatment for drug abuse.

Home Health Care Agency – A facility, licensed in the state in which it is located, which:

1. Provides skilled nursing and other services on a visiting basis in the Member's home; and
2. Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Home Infusion Facility – A facility which provides a combination of:

1. Skilled nursing services
2. Prescription Drugs
3. Medical supplies and appliances in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

Hospice – A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Hospital – A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

1. Provides room and board and nursing care for its patients;
2. Has a staff with one or more Physicians available at all times;
3. Provides 24 hour nursing service;
4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Treatment of alcohol abuse
8. Treatment of drug abuse

Laboratory (Clinical)

Licensed Practical Nurse

Licensed Professional Counselors

Occupational Therapist

Outpatient Psychiatric Facility – A facility which mainly provides Diagnostic and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.

Pharmacy – An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician’s order. A Pharmacy may be a Network Provider or a Non-Network Provider.

Physical Therapist

Physician – A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).

Psychiatric Hospital – A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

Psychologist – A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Registered Nurse First Assistant

Registered Nurse

Registered Nurse Practitioner

Regulated Physician’s Assistant

Rehabilitation Hospital – A facility that is primarily engaged in providing rehabilitation services on an

Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

Respiratory Therapist (Certified)

Retail Health Clinic – A facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.

Skilled Nursing Facility – A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial Provider or similar place.

Social Worker – A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.

Speech Therapist

Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices

Urgent Care Center - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money a Member receives from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how the Member, their representative, or any agreements characterize the money received, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

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

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

Single Coverage – Coverage that is limited to the Subscriber only.

Special Enrollment – A period of enrollment in which certain Eligible Persons or their Dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc.

Stabilize – The provision of medical treatment in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of a Member's condition is not likely to result from or during any of the following:

1. discharge from an Emergency department or other care setting where Emergency Care is provided; or
2. transfer from an Emergency department or other care setting to another facility; or
3. transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor – Anthem and/or Employer may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and Behavioral Health services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Anthem's or Employer's behalf.

Subscriber – An employee or Member of Indiana University who is eligible to receive benefits under the Plan.

Therapy Services – Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.

Preventive Care Services – Preventive Care services include Inpatient services, Outpatient services and Physician Home Visits and Office Services. These services may vary based on the age, sex, and personal history of the individual, and as determined appropriate by Anthem's clinical coverage guidelines. Screenings and other services are generally 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.

Health Savings Account

Section K — General Provisions

The Health Savings Account feature is a Health Savings Account (HSA)—an IRS-qualified feature that provides substantial tax savings and participant flexibility. The Health Savings Account benefit is established under Internal Revenue Code Section 223.

The University makes a 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 money can be left 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.

The Health Savings Account benefit is established with a bank custodian, JP Morgan Chase, contracted by Indiana University for use by its employees. The account, once established, is the responsibility of the participant. The Plan Administrator shall not be responsible for the adjudication of any claims or the payment of any reimbursement from the Health Savings Account Benefit.

Section L — Eligibility and Enrollment

Commencement of Participation

The Health Savings Account benefit is established by the HSA custodian on the first day of the month in which HDHP PPO coverage is in effect. If HDHP coverage is established after the first of the month, the Health Savings Account benefit will be established the first of the month following.

The Health Savings Account benefit cannot be established unless the participant is verified by the HSA custodian as meeting the requirements of the USA Patriot Act and any other applicable federal or state banking requirements. In the event such verification delays establishment of the Health Savings Account benefit beyond the first day of HDHP PPO medical coverage, the account will be established as soon as identification has been verified.

Enrollment

To enroll in coverage and establish the Health Savings Account benefit, an employee must complete an enrollment form electing participation in the HDHP PPO & Health Savings Account 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 the employee does not enroll within 30 days of becoming eligible for coverage, the employee cannot enroll until the next Open Enrollment period with an effective date of the following January 1.

An employee can change or drop plan coverage only during the annual Open Enrollment period, except if a midyear Change of Status occurs. Please see Section A for information on midyear enrollment changes.

Section M — Contributions

EMPLOYER CONTRIBUTION

Indiana University shall make an annual contribution to the participant's Health Savings Account benefit in an amount and manner specified and published to all eligible employees each year during Open Enrollment effective for the following plan year. The annual amount of the contribution will be based on the HDHP PPO coverage level elected by the participant. For 2011, the University's contribution is \$700 for employee-only coverage, and \$1,400 when one or more family members are covered. New eligible employees who enroll in the HDHP PPO & Health Savings Account during the year will receive the full annual University contribution if the effective date of the HDHP plan is prior to September 1. For participants with an enrollment effective date after September 1, no University contribution will be made for that plan year.

Indiana University shall contribute the difference between the employee-only and family member coverage level contributions when a Participant elects to add one or more family members to her/his HDHP PPO & Health Savings Account due to a change in status during the year so long as the effective date of the change of status is before September 1. No additional Indiana University contribution will be made for an enrollment change effective September 1 or after.

EMPLOYEE CONTRIBUTION

Minimum Contribution

Each participant is required to contribute a minimum amount to the Health Savings Account benefit. The minimum contribution is specified each year in Open Enrollment publications distributed to all eligible employees.

2011 Minimum Contribution: \$300

Maximum Contribution

The maximum amount an employee can contribute to her/his account is indexed with inflation and published each year by the US Treasury and IRS. The maximums shown below have already been adjusted for the University's contribution.

2011 Maximum Contribution:

Under age 55:

- Employee-only HDHP.....\$2,350
- Family HDHP*.....\$4,750

Age 55 or older (includes \$1,000 catch up):

- Employee-only HDHP.....\$3,350
- Family HDHP*.....\$5,750

**Family coverage includes Employee w/Spouse, Employee w/Children and Family HDHP Coverage.*

For any terminations during the year, the IRS requires that maximum contributions for partial year participation are prorated based on the number of months of participation. The IRS allows a maximum equal to 1/12th of the annual maximum for each month of participation. Any contributions in excess of the prorated maximum will

be included in gross income and subject to an additional excise tax if not withdrawn by April 15th of the next taxable year.

If the employee enrolls in the HSA mid-year and is enrolled on December 1st, the employee can contribute up to the full annual maximum amount for that year, as long as HDHP eligibility is maintained for a 12-month period. If eligibility is not maintained, contributions over the prorated maximum will be included in gross income and subject to an additional excise tax. Note the 12-month period starts with the last month of the taxable year in which HDHP enrollment commences. For example, an employee who enrolls in June 2011 must continue to be eligible from December 2011 - December 2012.

CONTRIBUTION ELECTIONS

The University annual contribution and employee's minimum annual contribution are automatic with enrollment in the HDHP PPO & Health Savings Account. However, the employee's designated contribution election above the minimum must be elected each year during Open Enrollment. If the employee does not elect a contribution above the minimum during Open Enrollment, only the minimum will be deducted unless a change is made as described in Contribution Changes below.

CONTRIBUTION CHANGES

The employee's annual contribution will be divided equally over pay periods. The contribution can be changed prospectively throughout the year, and the new amount to be deducted each pay period will be determined by subtracting the year-to-date payroll deductions from the new elected annual amount and dividing over the remaining pay periods for the year. Employees cannot change contributions to an amount less than the minimum required or less than what they have already contributed. Employees can make changes to their contribution by filling out a Health Savings Account Change Contribution form and submitting to the University Human Resource Services office.

Section N — Health Savings Account Benefits

The funds in the Health Savings Account benefit are available to pay or reimburse all IRS qualified health expenses. Funds are only available for use as the money is deposited into the account through pre-tax payroll deductions. All funds stay in the account indefinitely until used and stay with the employee even after the employee leaves the University.

IRS QUALIFIED ELIGIBLE EXPENSES

Eligible expenses must not already be paid by insurance and must be incurred after the Health Savings Account benefit was established. The expense can be for the employee, the employee's spouse or any eligible tax dependent. The IRS does not recognize domestic partners as eligible for preferential tax treatment unless the domestic partner is also a tax dependent of the employee. Detailed information about qualified health expenses can be found in Section 213(d) of the Internal Revenue Code and IRS Publication 502. Examples include:

- COBRA premiums
- Medical and dental plan deductibles and coinsurance
- Dental expenses, including orthodontia, dental cleanings and fillings
- Diabetic supplies
- Eye exams, eyeglasses, contact lenses and solutions
- Hearing aids
- Laser eye surgery
- Long-term care premiums
- Medicare premiums and copays (not Medicare supplement premiums)
- Over-the-counter medicines
- Prescription drugs
- Physical therapy, speech therapy and chiropractic expenses
- Specialized equipment and devices for disabled persons
- Transportation expenses related to medical care
- Weight reduction programs for physician-diagnosed obesity

ACCESS TO HEALTH SAVINGS ACCOUNT BENEFIT FUNDS

All participants will be provided with a debit card for the Health Savings Account. Funds in the account can be accessed by using the debit card provided at the point of care. Funds may also be withdrawn at an ATM using the debit card to reimburse for out-of-pocket expenses. Other options may be available at the employee's expense through the bank custodian.

IRS LIMITATIONS ON OTHER SPENDING ACCOUNTS

The IRS limits the use of the Tax Saver Benefit (TSB) and the HRA when an employee is enrolled in the Health Savings Account benefit. Until the deductible is met, only vision and dental expenses can be reimbursed from the TSB and HRA plans. Once the deductible is satisfied, these plans can be used for any IRS qualified medical expenses incurred after the date the deductible was met.

Section O — Reporting Requirements

Claim Substantiation

There is no claim substantiation required by the bank custodian or University with the Health Savings Account benefit. However, substantiation may be required by the IRS. Employees should save all receipts in case the IRS requires them. If requested by the IRS, the employee is required to produce receipts that show the fund distributions were used to pay or reimburse qualified medical expenses. Expenditures from Health Savings Account that cannot be substantiated are subject to taxation. See Taxable Income Situations below.

Tax Forms

The bank custodian will send the employee a 5498-SA and 1099-SA form at the end of the tax year to report contributions and withdrawals to the account. The IRS requires the employee to submit Form 8889 each year with her/his federal income tax filing. This form reports all employer contributions to the account including contributions made by the employee through payroll deduction.

Taxable Income Situations

All expenditures from the Health Savings Account benefit are to be used for IRS qualified medical expenses such that the funds are not taxable income. Any distributions not used for IRS qualified medical expenses will be subject to income taxes and an additional 20 percent tax penalty.

Section P — Termination of Coverage

Participation in the IU-sponsored Health Savings Account benefit will end as of the first to occur of:

- the date that the plan terminates; or
- the date on which the participant fails to make all required contributions; or
- the date that the participant's employment terminates or the participant is no longer an eligible employee; or
- the date that the participant's coverage in the HDHP PPO & Health Savings Account terminates; or
- the last day of the plan year in which the employee has elected participation in the plan (i.e. the employee must affirmatively elect participation in the Health Savings Account Benefit each plan year)

HEALTH SAVINGS ACCOUNT AFTER TERMINATION

When an employee's HDHP PPO & Health Savings Account coverage ends, he is no longer eligible to make contributions to the Health Savings Account benefit through IU payroll contributions. The employee will continue to have access to the funds to pay for qualified medical expenses. The HSA custodian will provide information to the employee describing HSA options for transferring the account funds to a personal account or other IRS allowed option after participation in the University benefit ceases.

LEAVE OF ABSENCE

When an employee is on an approved leave of absence, participation in the Health Savings Account benefit will continue so long as the employee continues to be enrolled in HDHP PPO coverage. Salary contributions will continue as long as the employee is receiving pay; however, salary contributions terminate when the employee is on leave without pay and contributions resume upon returning to a paid status. During a leave of absence, the employee may change the elected annual contribution amount at any time by completing the applicable form.

If the employee does not elect to continue coverage in HDHP PPO & Health Savings Account during a leave of absence, participation will terminate.

RECOMMENCEMENT OF PARTICIPATION

An employee who terminates participation as a result of no longer being an eligible employee or experiencing a change of status may resume participation in the Plan if she/he again meets eligibility requirements. A participant who resumes participation within the same plan year will be required to make salary reduction contributions sufficient to meet the annual minimum contribution required by the Plan; and, will receive no additional University contribution if the University's annual contribution for the plan year has already been made.

TAX CONSIDERATIONS WHEN TERMINATING MID-YEAR

The IRS prorates the maximum annual contributions when participation in a HDHP plan ends during the year. Any employee terminating during the plan year and not continuing HDHP coverage, either through the COBRA or another HDHP plan, should confirm contributions were not made in excess of the IRS prorated maximum. Details on the calculation of the IRS prorated maximum can be found in IRS publication 969. If contributions

have exceeded the IRS prorated maximum, the employee must work with the bank custodian and the University to resolve the excess contribution. Excess contributions not withdrawn from the Health Savings Account benefit are subject to a 6% excess tax until withdrawn. The employee should be aware of the reporting requirements for excess contributions as detailed in the instructions for IRS Form 8889.

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.

University Human Resource Services
400 E. Seventh St., Poplars E165
Bloomington, IN 47405-308