IU PPO-PLUS HEALTH CARE PLAN

Academic and Staff Employees

IU Wordmark

Medical Coverage
Administered by Anthem

Prescription Drug Coverage
Administered by Scrip Pharmacy Solutions
and Continental Pharmacy

Mental Health/Chemical Dependency Coverage
Administered by IUPM

University Benefits Office
January 2001

FOREWORD

This booklet describes the medical, pharmacy, and mental health/chemical dependency benefits that are provided by Indiana University through the IU PPO-Plus Health Care Plan. 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 receive a summary of the amendment or a revised booklet reflecting any changes made in the principal features.

The benefits described are effective January 1, 2001.

Principal Features:

This is a comprehensive health care plan with a choice of two coverage levels: In-Network and Out-of-Network. All covered charges are subject to copayments and deductibles, where applicable, unless otherwise stated.

Benefits under the Plan fall into four coverage components which are detailed in the following sections.

They are:

- Medical Coverage (Section B)
- Prescription Drug Coverage (Section C)
- Mental Health / Chemical Dependency Coverage (Section D)
- Organ and Tissue Transplant Coverage (Section E)

(The IU Dental Plan is a separate benefit plan and is described in a different booklet.)

Each coverage component has its own benefit design, e.g., provider network, cost sharing (deductible and copay) provisions, and medical management requirements. All components are subject to the same plan-wide General Provisions (Section A).

Administrative Services:

Contact a Human Resources office for the following administrative services:

- change name
- change in membership option
- obtain claim forms
- add or delete dependents
- cancel coverage
- obtain information on continuation of coverage following divorce or termination

Refer to the University Benefits Office website at *www.indiana.edu/~ubenefit* for:

- related customer service telephone numbers
- claim forms
- information on COBRA continuation coverage

IU PPO-Plus Health Care Plan -- Benefit Summary

(New plan effective January 1, 2001)

This summary describes essential features of the benefit plan and is not intended to be a full description of benefits. The complete plan is described in the Plan booklet that employees receive upon enrollment.

Medical Benefits - In-Network Providers: Anthem's PPN Network, Indiana and BCBS Networks, Outside Indiana		
Service/Provisions	**In-Network Member Payments**	**Out-of-Network Member Payments**
Plan Deductible	None	$300 per member
Covered Charges	Up to the network fee schedule, or Usual & Reasonable (U&R) for non-network providers; network providers accept network fee schedule as payment in full; member is responsible for non-network provider charges above U&R.	
Medical Copay	10%	30%
Medical Copay Maximum	$1,000 ($2,000 family) copay maximum, then there is no Medical Copay.	$3,000 ($6,000 family) copay maximum, then there is no Medical Copay.
Office Visit Copay	$15 per visit; other covered charges are subject to the Medical Copay.	$15 per visit; other covered charges are subject to the Medical Copay.
Hospital Inpatient Services **(all inpatient services must be pre-certified)** • Semiprivate room and board. • Operating room, recovery, ancillary services (e.g., labs x-rays, drugs).	$250 per admission; remaining covered charges are subject to the Medical Copay.	$250 per admission; remaining covered charges are subject to the Medical Copay.
Outpatient Facility • Operating room, recovery, ancillary services.	$100 per surgery; remaining covered charges are subject to the Medical Copay.	$100 per surgery; remaining covered charges are subject to the Medical Copay.
Professional Services (e.g., surgery fees)	Medical Copay	Medical Copay
Therapy: Occupational, Physical, Speech Combined limit per member per plan year: total of 60 visits.	$15 per visit; remaining covered charges are subject to the Medical Copay.	$15 per visit; remaining covered charges are subject to the Medical Copay.
Maternity Care and Delivery Services	Paid the same as any other medical services.	
Chiropractic Services / Osteopathic Manipulations Limits per member per plan year: 15 visits; $150 for diagnostic services.	$20 per visit; remaining charges are subject to the Medical Copay.	$20 per visit; remaining charges are subject to the Medical Copay.
Wellness Services Limits: $200 maximum payable for wellness services for enrollees over age 7. Services for school, sports, employment, marriage, or travel are excluded.	$15 per visit; remaining charges are subject to the Medical Copay.	$15 per visit; remaining charges are subject to the Medical Copay.
Emergency Room	$50 (waived if admitted); remaining charges are subject to In-Network Medical Copay if "emergency Accident or Illness," otherwise, Out-of-Network.	
Urgent Care Facility	$25; remaining covered charges subject to Medical Copay.	
Ancillary Care Facility* • Durable Medical Equipment/Supplies • Prosthetics and Corrective Appliances • Ambulance * Anthem has no PPN contracts for these services	10% of covered charges up to the Medical Copay Maximum. Home Health limit: 60 visits per member per year. Skilled nursing facility limit: 60 days per member per year. Ambulance air trip maximum benefit: $2,500 per trip.	
Vision / Hearing Aids	No benefit.	

Medical Benefits (continued)

Coverage Outside the Service Area	Member pays In-Network costs for non-network providers in certain cases: • Initial treatment of emergency accidents and illness anywhere. • Services for members residing "outside Indiana." • Services that Anthem determines are not reasonably available In-Network. • Emergency and urgent care for students living at schools outside Indiana. (Member pays amounts above Usual & Reasonable reimbursement for any non-network provider)

Mental Health and Chemical Dependency - IU Psychiatric Management Provider Network

All services, both In and Out-of-Network (except initial evaluation by eligible provider) must be authorized by IUPM to be covered.

Service	In-Network Member Payments	Out-of-Network Member Payments
Inpatient	• $250 deductible. • 10% copay until copay equals $500 per episode, then there is no copay.	• $500 deductible per admission. • 20% copay on the first $2,500 of covered charges, then 40% of covered charges. • No copay maximum.
Outpatient	• $20 copay per visit. • $50 Emergency Room copay.	• $30 per visit. • $50 maximum per covered visit. • $50 Emergency Room deductible.

Organ and Tissue Transplants Phase III - IU Medical Center / Clarian Transplant Programs

Service	In-Network Member Payments	Out-of-Network Member Payments
Transplants: Bone marrow, heart, lung, liver, pancreas, kidney	• No deductible. • No copay.	No Out-of-Network benefits.
Lifetime Maximum	$1,000,000 per member.	

Prescription Drugs - custom third-party network

Service	In-Network Member Payments	Out-of-Network Member Payments
Retail Prescriptions (up to a 30-day supply) Network: CVS, Osco and Dominick's	• No deductible. • $5, generic and brands with generic* • $10, low-cost brands (up to $60) • $25, high-cost brands ($60 or more) • Non-covered, network discount - 100% * For brand with generic, member pays generic copay and cost difference between brand and generic.	50% copay, plus amounts above the network's discounted price.
Mail Order (up to 90-day supply) Network: Continental Pharmacy	2 times the above retail; copay.	
Diabetic Supplies (see retail and mail order)	Covered as a prescription drug benefit.	
Specialty Drugs (certain biological and injectable drugs for chronic diseases)	Covered with no copay through BioScrip provisions; otherwise covered as a medical benefit, subject to Medical Copays and Deductible, as applicable.	

Frequently Asked Questions About Exclusions (complete list in Section F of the Plan booklet)

- Any service not medically necessary as determined by the Plan Administrator.
- Custodial care and long-term nursing care.
- Cosmetic surgery, procedures and drugs.
- Experimental/Investigational services.
- Supportive devices for the feet and routine foot care.
- Services for which coverage is provided or is required by law or by a public/governmental agency, facility or program.
- Drugs, devises or services related to sexual dysfunction, sexual transformation, infertility, reversal of sterilization, and growth deficiencies.
- Acupuncture.
- Service, supplies and drugs for obesity or weight control.
- Over-the-counter drugs; drugs not FDA approved.
- Vitamins other than federal legend vitamins.
- Services and supplies used to treat conditions to the extent that, according to generally accepted Professional Standards, such conditions are not amenable to favorable modification through medical treatment.
- Additional costs incurred due to the enrollee disregarding medical advise or hospital costs for leaving the hospital against medical advise.

Claims Questions:

Call Anthem's IU Service Center at 800-382-4055 for claims questions related to medical services.

Call IUPM at 800-230-4876 for claims questions related to mental health or chemical dependency services.

Network Providers:

Call Anthem's IU Service Center at 800-382-4055 for information on medical network providers, including primary care physicians, or use the Anthem web page: *www.anthem-inc.com*

For information on Blue Cross and Blue Shield network providers outside Indiana, use the Blue Card web page: *www.bluecares.com* or call 800-810-2583.

Call IUPM at 800-230-4876 for information on mental health/chemical dependency network providers.

Call Scrip Pharmacy Solutions at 800-213-5640 for participating pharmacies.

Utilization Management:

Call Anthem at 800-367-4207 for pre-certification of all medical hospital admissions.

Call IUPM at 800-230-4876 for prior authorization of all mental health/chemical dependency services.

Pharmacy Network:

Call Scrip Pharmacy Solutions Customer Service at 800-213-5640 concerning retail prescriptions.

For questions regarding Mail Order prescriptions, call Continental Pharmacy at 800-677-4323.

Mail Order prescriptions may be refilled online at *www.iubenefitsRx.mimrx.com*

Mental Health and Chemical Dependency:

Call Indiana University Psychiatric Management (IUPM) at 800-230-4876 for prior authorization of all mental health/chemical dependency services, or for questions about plan benefits or claim questions.

Please read this booklet carefully.

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SECTION A — GENERAL

ELIGIBILITY FOR PLAN MEMBERSHIP

Eligible Employees

Persons employed by Indiana University, on a full-time appointed basis to a position of expected duration of at least one full academic year, or a minimum of nine consecutive months, if not an academic year position. (Excludes individuals with Non-FICA student status.)

Effective Date of Coverage

Coverage becomes effective on the first day of active employment as an eligible employee, if the employee has enrolled within 60 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 mid-year addition of eligible dependents is effective as of the date of the "change of status" but only if the written request is received within 60 days of the event. (See ENROLLMENT next page). After 60 days of the date a dependent becomes newly eligible, a dependent cannot be added until the next Open Enrollment with an effective date of the following January 1.

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.)

Eligible dependents include:

- employee's spouse as defined by Indiana law;
- unmarried children, up to the end of the calendar year in which the child attains age 23, who are claimed as the employee's or employee's spouse's dependent for Federal Income Tax purposes and who are:
  - — a biological child;
  - — lawfully adopted child;
  - — lawful stepchild; or
  - — child for whom the employee or the employee's spouse has been lawfully appointed sole legal guardian for an indefinite period of time.
- The requirement for a child to be claimed as a dependent on the employee's or employee's spouse's Federal Income Tax filing is waived in the event the child qualifies as a Federal Income Tax dependent and the employee is legally required to provide health coverage under a "Qualified Medical Support Order" as defined by ERISA or an applicable Indiana state law.
- When an adoption is in the legal process, coverage for such child may begin from the point the child is placed in the employee's home for the purpose of adoption.
- A fully disabled child may be able to continue Plan coverage beyond age 23 — see page 5.

No individual may be eligible for benefits both as 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. A spouse or a child who is on active duty in the armed forces of any country will not be eligible for benefits under this Plan.

All spouses and dependent children of covered employees are third-party beneficiaries of this Plan.

Proof that an individual is a qualified dependent is required at the time of initial enrollment and periodically thereafter. Failure to provide proof of dependent eligibility within 60 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.

See page **5** concerning disabled children.

Newborn Coverage

The newborn child of a covered employee will be covered immediately from birth for the first 31 days if the employee was covered under the Plan on the child's date of birth. 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 60 days after the child's birth, 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. The newborn child must meet the definition of dependent explained above.

ENROLLMENT

To enroll in coverage, it is necessary to complete an enrollment form within 60 days from the first date of active employment, or within 60 days of the date that the employee first becomes a member of the eligible class or during an Open Enrollment period.

All coverage is contributory, and a schedule of rates will be provided to show the contribution amount required for various membership options.

If the employee does not request coverage during an Open Enrollment period or within 60 days of initial employment, coverage will not be allowed until the next January 1, assuming the employee requests coverage during the associated Open Enrollment period, except as noted below.

The employee can change or drop plan coverage membership only once a year — during the annual Open Enrollment period. This choice becomes effective on January 1 of each year and cannot be changed until the next annual Open Enrollment period. If the employee does not return a new enrollment form during the annual Open Enrollment period, the present choice will continue at the next year's contribution rate.

Mid-Year Changes in Enrollment

In addition to the annual Open Enrollment period, if the employee experiences a significant change in status, the employee can make a corresponding revision to the election as of the date of the event if the event is reported to Indiana University within 60 days of the event. Significant changes in status include (as defined by federal regulations):

(1) A change in family status (marital status or number of dependents) including marriage, divorce, death of a spouse or dependent, birth or adoption of a dependent, disqualification or re-qualification of a dependent child; or

(2) Termination or commencement of employment by the employee, employee's spouse or dependent child; or
(3) Change in work schedule of the employee, employee's spouse or dependent child, including a change from full-time to part-time or from part-time to full-time, or commencement of or return from an unpaid leave (LWOP) or disability; or
(4) A change in the place of residence or worksite of the employee, employee's spouse, or dependent child; or
(5) Substantial change in the scope of coverage or cost of coverage of the employee's spouse's health coverage provided by his or her employer, or
(6) Change in Medicare or Medicaid eligibility.

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

- 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
- the change in enrollment in this Plan corresponds with that gain or loss of coverage.

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 Part A, and provisions for enrollment changes are subject to Internal Revenue Code Section 125.)

If the employee is still working and eligible for Medicare and has selected coverage under this Plan, Medicare will be secondarily responsible for any benefits. If the employee elects not to be covered under this Plan, there will be no coverage under this Plan.

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 Indiana University-sponsored Retiree health care plan available at that time. Please contact a campus Human Resources office or the University Benefits Office to initiate such an enrollment.

TERMINATION OF COVERAGE

Coverage under this Plan will terminate at the end of the month during which:

- employment terminates, or
- the employee ceases to be a member of the eligible class for coverage.
- 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.

Coverage under this Plan will terminate upon the discontinuance of the Plan as a whole.

Notice of Ineligibility:
The employee is responsible for notifying the University of any changes which affect the employee's spouse or dependent child eligibility, for example, marriage or divorce. Notice must be received *in writing* within 60 days of the change.

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 employee coverage,
- when such person ceases to meet the definition of dependent, or
- when the employee coverage terminates.

A dependent child, who is unmarried and is an IRS dependent of the employee or employee's spouse, may continue to be eligible to the end of the calendar year in which the child attains age 23. Proof that the child is a qualified dependent may be required at the time of initial enrollment and periodically thereafter.

Disabled Child Coverage

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:

- the child continues to meet the criteria, except for age, for an eligible child in the "Eligible Dependent" section of this plan booklet;
- the child is covered under an IU-sponsored health care plan at the time of reaching the maximum age for dependent child coverage;
- the employee continues to be covered;
- the employee continues to maintain dependent coverage under the Plan; and
- the dependent child meets both of the following criteria:

1) The child is financially dependent on the employee, as evidence by:
    a) the child being claimed by the employee or the employee's spouse as an income tax dependent; and
    b) the child not having resources (for example: trust fund or settlement) that would sustain the child financially; and
2) The child is incapable due to physical or mental disability of engaging in self-sustaining employment as evidenced by:
    a) a physician's statement of the diagnosis, prognosis, and specific resulting symptoms that prevent the individual from being gainfully employed; and
    b) 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 coverage as a dependent would have ceased. Indiana University has the right to require, at reasonable intervals, proof that the child remains fully disabled and 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.

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 60 days of the change in status.

If the employee does not request a change in participation in the IU PPO-Plus Health Care Plan at the commencement of an unpaid leave, the employee is responsible for making arrangements to pay the employee contributions during the unpaid leave of absence. Failure to make contributions will result in termination of participation in the Plan. Upon return from the unpaid leave, the employee may make a request to reinstate coverage so long as the request is made *in writing* within 60 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.)

Release of Medical Records and Information

On the Plan enrollment form the Employee authorizes the release of any medical records and information concerning claims, conditions, or treatment of the Employee, the Employee's spouse, and/or the Employee's dependents enrolled in the Plan, by any provider of health services to the Plan Sponsor and its subsidiaries, affiliates, and any administrators, reinsurers, agents, or other entities providing services on behalf of the Plan Sponsor. This information is for purposes which include but are not limited to: processing applications for enrollment; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; case management; quality improvement programs, reviews and audits; peer review; health care research; public health reporting; utilization review; coordination of benefits; subrogation; health promotion, disease management/prevention, and any other managed care/prevention program.

The Plan Administrator may furnish such information that it receives, upon request to the Plan Sponsor or its representative. The Plan Administrator may also furnish this information to other entities, including but not limited to: third-party administrators, pharmacy benefit managers, insurers; and government agencies. **No medical records or information will be shared with any individuals that make employment decisions at Indiana University.**

Any person or entity having information about an illness or injury for which benefits are claimed may give the Plan Administrator, Plan Sponsor, or anyone acting on the Plan Administrator's behalf any information about the illness or injury. The Plan Administrator may provide any person or entity any information about an illness or injury upon its request, if it is providing similar benefits. Benefits will not be provided where sufficient information cannot be obtained to properly process a claim. The Member waives any and all privileges with respect to such information, except that information about an illness, injury or claim will not be shared with any individual at the University that makes employment decisions.

By signing the application form, the Employee also agreed and consented to the recording and/or monitoring of any telephone conversation between the Member and the Plan Administrator.

The Plan Administrator's Customer Service Area may release information to the Employee or the Employee's spouse concerning a claim for benefits, or the Member’s coverage under this Plan. If the Employee does NOT want the Plan Administrator to release such information to another Member, the Employee must notify the Plan Administrator in writing. The Employee’s Spouse or any dependent child over age 18 must also notify

the Plan Administrator in writing if they do not wish such information regarding their claims or coverage released to another Member by Customer Service. However, the Plan Administrator's Explanation of Benefit forms will contain information on all claims for benefits under the Employee's coverage, and will be sent to the person in whose name the coverage is held (except as prohibited by law).

CONTINUATION OF COVERAGE (COBRA)

This is an important notice that the employee and dependents should read.
Federal law requires that the University offer 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 below 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 to run on the later of either the date that the qualified beneficiary would lose coverage due to the change in 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 in 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 in Status and Qualified Beneficiaries

The following qualified beneficiaries have the right to continuation coverage when one of the following changes in 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 the Employer'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 experience 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 in 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 in status as described in 1. and 3. above, 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 in Status and Qualified Beneficiaries," continuation coverage is provided for 36 months after the date of the initial change in status.
2. For the event explained in paragraph "2" under Changes in Status and Qualified Beneficiaries," continuation coverage is provided for 18 months after the date of the change in status.

Exceptions:

- A. If the change in status under paragraphs "1," "3," "4," or "5" above 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 in Status and Qualified Beneficiaries," continuation coverage will be extended an additional 11 months. 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 the employer within 30 days after the final determination is made under Titles II and XVI.
- C. If the Subscriber became entitled to Medicare prior to the change in 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" above, continuation coverage is provided until the death of the retired covered Subscriber. If the covered Subscriber dies before the occurrence of the change in 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" of the preceding section.

The maximum period for all changes in status is 36 months, except as may occur under paragraph "3" immediately above.

Premiums

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

Cancellation

Continuation coverage will terminate if:

1. The Plan Sponsor ceases to provide any group health Plan to its Members;
2. premiums are not paid on time;
3. upon the date, after the date of continuation coverage election, the qualified beneficiary first becomes covered under another group health plan that:
    A. does not contain any limitation regarding a pre-existing condition of the beneficiary; or
    B. 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;
4. 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 "Qualifying Events and Qualified Beneficiaries," first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or
5. a qualified beneficiary who was disabled under paragraph "2," under "Changes in 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. Under COBRA, the participant has at least 60 days from the date the participant would lose coverage to inform Indiana University that he or she wants to continue coverage. If the participant does not choose COBRA continuation coverage, benefits under this Plan will end, based on the provisions described in Termination of Coverage (see page 4).

GENERAL PROVISIONS

Coordination of Benefits:

If the enrollee or one of the enrollee's dependents is covered by another Plan, and both plans cover the same service, benefits for medical services (including mental health and chemical dependency, and organ and tissue transplants) covered by this Plan will be reduced, if necessary, so that the combined benefits of all plans covering the member do not exceed the covered benefit provided by this Plan, including payments and deductible amounts of the other Plan.

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.

One plan will be designated "primary," and the other "secondary," according to the Order of Benefit Determination Rules listed below. When this Plan is the primary plan it will pay its normal benefits. When this Plan is the secondary plan, it will pay the difference between what the primary Plan has paid plus its deductible, and the covered benefit under this Plan. It is intended that neither plan will provide more benefits under this coordination of benefits provision than it would if there were no other coverage. If any plan that is primary denies or reduces benefits because the participant chooses not to use an authorized provider facility and/or individual, this Plan will not pay any more than it would have paid, had the denial or reduction not occurred.

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 utilization management guidelines of the primary plan.

Order of Benefit Determination Rules

A. When there is a basis for a claim under this Plan and another Plan, this Plan is the Secondary Plan if:
   i. the other Plan does not have rules coordinating its benefits with this Plan; or
   ii. either the other Plan's rules, this Plan's rules, or both, require that this Plan's benefits be determined after those of the other Plan, except as may occur under the gender rule exception in B.ii.b. on this page.

B. This Plan's rules for determining the order of payment of benefits follow, using the first of the rules which applies:
   i. the Plan covering the Member as the Subscriber shall be deemed to be the Primary Plan and is obligated to pay before the Plan covering the Member as a dependent;
   ii. in the case of a dependent child, when the parents are neither separated nor divorced;
      a. the Plan covering the Member as a dependent of the Subscriber whose birthday falls earlier in the year shall be deemed to be the Primary Plan and is obligated to pay before the Plan covering the Member as a dependent of the Subscriber whose birthday falls later in the year;
      b. if both Subscribers have the same birthday, the Plan which has covered the Subscriber longer shall be deemed to be the Primary Plan and is obligated to pay before the Plan which has covered the other Subscriber for a shorter time.

EXCEPTION: If the other Plan does not have the rule described in ii. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

   iii. In the case of a dependent child, when the parents are separated or divorced, the first of the following which applies will determine the Primary Plan:
      a. the Plan which covers the child as a dependent of the parent with custody of the child;
      b. the Plan which covers the child as a dependent of the spouse of the parent with custody;
      c. the Plan which covers the child as a dependent of the parent without custody;

EXCEPTION: If there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, and the Plan Administrator has actual knowledge of the court decree, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility will be deemed the Primary Plan. If the specific terms of a court decree state that the parents shall have joint custody without stating that one of the parents is responsible for the medical, dental or other health care expenses of the child, the Plans covering the child shall follow the order of payment in accordance with ii. above.

iv. the Plan which covers the Member as a Subscriber who is neither laid off nor retired shall be deemed to be the Primary Plan for that Subscriber and any dependents and is obligated to pay before the Plan covering that Member as a laid off or retired Subscriber and any dependents. If the other Plan does not contain this provision 'iv', and if, as a result, the Plans do not agree on the order of benefits, this provision iv. is to be ignored.

v. where the order of payment cannot be determined in accordance with i, ii, iii, and iv above, the Primary Plan shall be deemed to be the Plan which has covered the Member for the longer period of time.

C. "Plan" means this Plan and any other arrangement providing health care or benefits for health care through:
   i. Group insurance coverage, health maintenance organizations, self insurance plans, and preferred provider organizations;
   ii. Prepayment coverage;
   iii. Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee plan, a union welfare plan, an employee organization plan or an employee benefit organization;
   iv. Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization;
   v. Any government program except Medicare or Medicaid;
   vi. The medical payments and/or No-fault provisions of automobile insurance;
   vii. Any other group type coverage as permitted by law.

D. A "Plan" is not any of the following:
   i. Individual or family coverage, including insurance contracts, subscriber contracts, coverage through health maintenance organizations or other prepayment group practice and individual practice plans which are not group coverages.
   ii. The first $100.00 per day payable by a group or group-type Hospital indemnity plan.
   iii. Any school accident-type coverage for elementary, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis.
   iv. Any other coverage when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

To coordinate benefits, the Administrator will release or obtain information regarding a claim from any insurance company, organization, or person. Participants claiming benefits must furnish the Administrator with any information necessary to coordinate benefits.

The Administrator is not liable for any failure to coordinate benefits. If the Administrator pays full benefits on a claim for which it had only secondary liability, the Administrator may recover the difference from the enrollee or from any other appropriate party. This applies even if the Administrator knew there was other plan liability at the time payment was originally made.

Right of Recovery:

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

SUBROGATION - REIMBURSEMENT

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

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

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

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

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

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

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

The Plan Sponsor in its sole discretion may elect not to enforce this subrogation/reimbursement provision.

DEFINITIONS

Anthem — The administrator of the medical benefits, who provides administrative claim payment, medical management, and network management services only and does not assume any financial risk with respect to claims.

Average Wholesale Price (AWP) — The published average cost of a drug product paid by the pharmacist to the wholesaler. This price is specific to drug strength or concentration, dosage form, package size, and manufacturer or labeler.

Chemical Dependency — A condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

Chronic Mental Health Conditions — A condition is "chronic" if the condition meets the following criteria:

1. The patient must have a primary diagnosis in the "Diagnostic and Statistical Manual of Mental Disorders - IV" in which symptoms have persisted for over a period of one (1) year even with treatment.
2. The patient must meet one of the following (A or B):
   - A. The patient has received more than two times in the past two years of psychiatric treatment more intensive than routine outpatient services. Examples of more intensive services would include, but are not limited to, the following:
     - attendance in a community support program for the Chronically Mentally Ill;
     - attendance in a day treatment program;
     - attendance in a socialization or drop-in program;
     - attendance in outpatient services that are determined to be needed continuously and indefinitely;
     - more than two (2) hospitalizations;

     - OR -
   - B. The patient must have experienced a single episode of continuous structured supportive residential care other than hospitalization for a period of at least three (3) months. This means patients who are living in (a) semi-independent apartments; (b) alternative family care facilities; (c) supervised group living; or (d) cluster apartment living where a residential services manager is involved with the patient.

Continental Pharmacy — The network mail order pharmacy for the Plan's outpatient prescription drug benefit.

Copayment — The percentage or fixed amount of covered charges for which the enrollee is responsible. The copayment takes effect after any plan deductible (if applicable) is met.

Copayment Maximum — The amount of medical copay an enrollee (or family) must pay before the medical benefit increases to 100% of covered charges for covered services.

Covered Charges — Charges for covered services to the extent that, in the Administrator's judgment, as authorized by the enrollee's plan sponsor, are not excessive. The Administrator will base its judgment on one or a combination of the following: (1) a negotiated rate based on services provided; (2) a fixed rate per day; or (3) the Usual and Reasonable (U&R) allowance for similar providers who perform like covered services.

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

Custodial Care —

1. Care with the primary purpose of assisting the enrollee with activities of daily living, or in meeting personal, rather than medical needs;
2. which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or medical condition; and
3. which can be provided by persons with no formal medical skills or training.

The Administrator, on behalf of the Plan sponsor, will determine, based on medical evidence, whether care is custodial.

Deductible — The specified dollar amount of covered charges that the enrollee must incur before the Plan will assume any liability for all or part of the remaining covered charges.

Dependent — A person of the employee's family who meets the Eligible Dependent guidelines in the "ELIGIBILITY FOR PLAN MEMBERSHIP" section of this book. Dependents must be added within 60 days of acquiring legal dependent status by contacting a Human Resources office.

Diagnostic Services — The following procedures are covered when medically necessary and ordered by a provider individual because of specific symptoms, in order to determine a definite disease or condition:

1. radiology, ultrasound, and nuclear medicine;
2. laboratory and pathology;
3. EKGs, EEGs, and other electronic diagnostic medical procedures; and
4. neuropsychological testing.

These services, when ordered for the purpose of distinguishing those who are well from those who have an undiagnosed disease or condition, are considered to be Screening Tests. The fact that a Physician may prescribe a diagnostic service does not, of itself, make such treatment a covered service.

Effective Date — The date on which the enrollee's coverage begins under the Plan according to the IU PPO-Plus Health Care Plan Enrollment Form.

Emergency — An emergency is a sudden and/or unanticipated sickness, injury or change in existing medical condition which would jeopardize a person's life or cause serious impairment to bodily functions if health care is not given immediately.

Employee — A person directly employed in the regular business of, and compensated for services by Indiana University.

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

Experimental — see **Investigational.**

High Dose Chemotherapy — The use of chemotherapeutic agent or agents for treating, or for preventing recurrence of, cancer or cancer-like illness, with or without irradiation, in doses which exceed the FDA approved or commonly recognized dosage range for the drug or drugs employed, and which is expected to result in effects upon the bone marrow which would likely be lethal if untreated.

Identification Card — A card issued by the Administrator, on behalf of the Plan Sponsor, that bears the employee's name, employee's social security number, identifies his or her membership level, and may contain further information about his or her coverage.

Inpatient — An enrollee who is treated as a registered bed patient in a provider facility and for whom a room and board charge is made.

Investigational/Experimental —

1. Any drug, device, diagnostic, product, equipment, procedure, treatment, or supply ("Service") 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 Experimental or Investigational, or in other terms that indicate that the Service is being evaluated for its safety, toxicity, or efficacy.

2. Any Service not deemed Experimental or Investigational based on the criteria in section (1.) above may still be deemed experimental or investigational 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 Experimental or Investigational based on the criteria in sections (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 Experimental or Investigational Service, or those provided to treat anticipated or unanticipated results of an Experimental or Investigational Service, will also be excluded from coverage. Services that are part of the same plan or evaluation or treatment as an Experimental or Investigational 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 Experimental or Investigational 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 Experimental or Investigational under this Plan.

IUPM — The administrator of the mental health and chemical dependency benefits is IUPM (Indiana University Psychiatric Management).

Lifestyle Related Service — An elective health care service, supply or drug that enhances the lifestyle of the recipient and that:

- does not pose a serious health risk or cause material deterioration of the individual's condition if it is not elected; and
- is not specifically listed as a covered service in this booklet.

Limiting Age — The end of the calendar year of the covered child's 23rd birthday.

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

- appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards;
- not primarily Custodial in nature;
- not primarily a Lifestyle Related Service;
- not Experimental/Investigative or unproven;
- not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment, and as to institutional care, cannot be provided in any other setting, such as a Physician's office or the outpatient department of a Hospital, without adversely affecting the patient's condition; and
- not provided only as a convenience or preference to the enrollee, physician or other provider, person or institution.

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

Medicare — The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Illness — A clinically significant behavioral or psychological disorder marked by a pronounced deviation from a normal healthy state and associated with a present painful symptom or impairment in one or more important areas of functioning. This disease must not be merely an expected response to a particular stimulus. Under the enrollee's plan, mental illness does not include substance abuse disorders. The Administrator, on behalf of the enrollee's plan sponsor, will make final benefit determination based upon reasonable medical evidence. (Stress and personal growth issues are not a mental illness.)

Open Enrollment — The employee's annual opportunity to make changes to their health care coverage including: selecting a different plan; adding or dropping dependents; or adding or dropping dental coverage. Changes outside the Open Enrollment period are subject to Internal Revenue Code Section 125, which limits changes to certain prescribed changes in status.

Outpatient — An enrollee who is a patient, other than a bed patient, at a provider facility.

Plan — The group health care Plan provided by the enrollee's plan sponsor and explained in this booklet.

Plan Membership — An enrollee's or a dependent's right to benefits subject to exclusions, limitations, and conditions described in this benefit booklet.

Plan Sponsor — Indiana University

Provider — The facilities and individuals listed below:

Provider Facilities:

Ambulatory Surgical Facility — A facility so licensed by the state in which it operates. If that state does not issue such a license, it means a facility with an organized staff of physicians which:

1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
2. provides treatment by or under the supervision of physicians, and nursing services whenever the patient is in the facility;
3. does not provide inpatient accommodation;
4. is not, other than incidentally, a facility used as an office or clinic for the private practice of a provider individual; and
5. has appropriate government planning approval, if required by its state law.

Clinical Laboratory — A laboratory that performs clinical procedures and is not affiliated or associated with a hospital, physician, or other provider.

Freestanding Dialysis Facility — A facility which is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an outpatient or home care basis.

Home Health Care Agency — An agency meeting Medicare requirements and licensed to provide home health care by the state(s) in which it operates:

Hospice — An agency that provides counseling and medical services, and may provide room and board to a terminally ill insured, and which:

1. has obtained any required state or governmental certificate of need approval;
2. is licensed by the state, federal government, or any other appropriate government authority, if such licenses are issued;
3. provides services 24 hours a day, 7 days a week;
4. is under the direction of a Physician;
5. has a nurse coordinator who is a registered nurse;
6. has a licensed Social Worker (social service coordinator);
7. has a primary purpose to provide hospice services;
8. has a full-time administrator;
9. maintain written records of services provided to the patient.

Hospital means the following:

Community Mental Health Center -- A facility which:

1. offers a program of services approved by the Indiana Department of Mental Health, or by the state in which it operates;
2. is organized for the purpose of providing multiple services for persons with mental illness, including substance abuse; and
3. is operated by one or more of the entities named in Indiana Code 12-7-2-38, or by similar entities of the state where it is located.

Hospital-- A facility which is a short-term, acute care general hospital and which:

1. is a duly licensed facility;
2. is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians, for compensation from its patients;
3. has organized departments of medicine and major surgery; and
4. provides 24-hour nursing service by or under the supervision of RNs.

Non-participating Hospital -- A facility licensed as an acute care general hospital, community mental health center, or psychiatric hospital by the state of Indiana and which has not entered in the Anthem PPO Health Network.

Psychiatric Hospital -- A facility licensed by the state in which it operates to provide diagnostic and therapeutic services for inpatient treatment of mental illness, including substance abuse. If the state does not issue such licenses, a psychiatric hospital is a facility which is primarily engaged in providing diagnostic and therapeutic services for the inpatient treatment of mental illness and substance abuse, if: (1) such services are provided by or under the supervision of an organized staff of physicians; and (2) continuous nursing services are provided by RNs.

Pharmacy — A facility so licensed by the state in which it operates.

Skilled Nursing Facility (SNF) — a facility which is:

1. licensed by the state in which it operates;
2. approved by Medicare; and
3. engaged primarily in providing skilled nursing and related services on an inpatient basis to patients requiring 24-hour skilled nursing services, but not requiring confinement in a hospital.

A skilled nursing facility is not, other than incidentally, a place that provides:

1. minimal care, custodial care, ambulatory care, or part-time care services; or
2. care or treatment of mental illness, substance abuse, or pulmonary tuberculosis.

Provider Individuals (as acting within the scope of their license):

Certified Registered Nurse Anesthetist — Any individual licensed as a registered nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by (1) the American Association of Nurse Anesthetists, or (2) that state's appropriate licensing board. An anesthetist must maintain certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

Chiropractor — A person licensed as such by the state in which he or she practices. If that state does not issue such licenses, a chiropractor is a person certified as such by an appropriate professional body.

Licensed Practical Nurse (LPN) — A person who has graduated from a formal practical nursing education program and is licensed as such by appropriate state authority.

Nurse Midwife — A nurse who has received special training in obstetrics, is qualified to deliver infants, and who is licensed by the State at the time delivery is performed provided the State in which such services are performed has legally recognized nurse-midwife delivery.

Occupational Therapist (OT) — A person who is licensed as such by the state in which he or she practices. If that state does not issue such licenses, an occupational therapist is a person certified as such by an appropriate professional body.

Psychologist — A person certified by the Indiana State Board of Examiners in Psychology. Outside of Indiana, it is a person licensed or certified as such by the state in which he or she practices. Where there is no state licensor or certification, the psychologist must be certified by an appropriate professional body.

Physical Therapist (PT) — A person licensed as such by the state in which he or she practices. If that state does not issue such licenses, a physical therapist is a person certified as such by an appropriate professional body.

Physician — A person performing services within the scope of his or her license, who is a duly licensed (1) doctor of medicine (MD); (2) doctor of osteopathy (DO); (3) dentist; (4) podiatrist; (5) optometrist; or (6) psychologist who has been endorsed as a "health service provider in psychology" by the Indiana State Board of Examiners in Psychology.

Registered Dietician (RD) — A person who is licensed as such by appropriate state authority.

Registered Nurse (RN) — A person who is licensed as such by appropriate state authority.

Respiratory/Inhalation Therapist — A person who is licensed as such by the state in which he or she practices. If that state does not issue such licenses, a respiratory/inhalation therapist is a person certified as such by an appropriate professional body.

Speech Pathologist or Speech Therapist (ST) — A person so licensed by the state in which he or she practices. If that state does not issue such licenses, a speech pathologist or speech therapist is a person certified as such by an appropriate professional body.

Social Worker — A person who has received a Masters of Social Work degree from an accredited college or university.

Visiting Nurse's Association — An agency that is: (1) licensed by the state in which it operates; and (2) certified by the National League for Nursing Services.

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

Screening Tests — Diagnostic services ordered for the purpose of distinguishing those who are well from those who have an undiagnosed disease or condition. Screening tests are only covered when Medically Necessary as determined by the Plan Administrator. The fact that a screening test is ordered by a provider does not, of itself, make such test a covered service.

Scrip Pharmacy Solutions — the administrator of the prescription benefits, who provides claim payment, utilization management, and network management services only and does not assume any financial risk with respect to claims.

Spouse — The person recognized as the enrollee's husband or wife under the laws of the State of Indiana.

Subscriber — An employee or retiree of the employer who is enrolled under the IU PPO-Plus Health Care Plan and is eligible to receive benefits under the terms of the Plan.

Usual and Reasonable (U&R) — The allowance measured and determined by comparing actual payments accepted by providers for similar services and supplies for individuals with similar medical conditions and may include other factors the Plan Administrator determines are relevant, including, but not limited to, a resource based relative value scale. When covered charges are based on the U&R allowance, the Plan Administrator, on behalf of the Plan Sponsor, will pay plan benefits up to the U&R allowance or billed charges, whichever is less.

SECTION B — MEDICAL COVERAGE

In Indiana University's continuing efforts to provide excellent health care benefits with quality health care providers in a cost effective manner, a Preferred Provider Organization (PPO) health benefit plan is offered utilizing Anthem preferred provider networks and medical utilization management services.

The features of the MEDICAL COMPONENT of the IU PPO-Plus Healthcare Plan are:

- This PPO plan provides benefits at two levels: In-Network and Out-of-Network.
- Designated Anthem and Blue Cross and Blue Shield networks are the preferred providers for In-Network benefits.
- Utilization Management for medical services is provided through the Anthem Utilization Management process.

PREFERRED PROVIDER NETWORKS

In-Network benefits are paid for services received from designated preferred providers:

- Premium Preferred Network (PPN), Anthem's Indiana based PPO network
- Option 2000, Anthem's Kentucky based PPO network, and
- Blue Cross and Blue Shield provider networks outside Indiana.

These networks of health care providers are intended to control health care costs while providing quality care and without reducing benefits. Providers in Anthem's networks agree to accept reduced reimbursements for their services, and, as a part of Anthem's quality improvement program, these network providers must meet certain credentialing standards in order to participate. Anthem network providers also agree to use cost-effective PPN ancillary networks, such as laboratory networks, which Anthem may incorporate into their networks from time to time.

In the case of some types of health care providers, Anthem has not established a network. Provider types without an established network are considered to be "exempt" providers; they include durable medical equipment providers and ambulance services.

In-Network Benefits

This option affords the lowest out-of-pocket expenses for the enrollee. In-Network benefits are paid when services are:

- received from preferred health care providers, and
- approved through the Anthem Utilization Management process, as required (see the Utilization Management Section on page **23**.)

Some of the advantages of In-Network benefits are:

- full plan benefits;
- preferred medical providers accept a fee schedule as payment in full with no balance billing (except copays);
- enrollees are not responsible for services which are determined to be not medically necessary unless the PPN provider has notified the enrollee that the services are not medically necessary and the enrollee elects to have the services performed;
- network providers are routinely credentialed under Anthem's Quality Improvement Program.
- network providers normally submit claims to Anthem or Blue Cross and Blue Shield on behalf of the patient.

Out-of-Network

This option offers some additional freedom of choice, but involves greater out-of-pocket expenses. Out-of-Network benefits are paid when the enrollee seeks care from providers who are not participants in the preferred provider networks (other than "exempt providers"). The consequences of using Out-of-Network services are:

- a lower level of benefit which means higher out-of-pocket costs through deductible and higher copays;
- the enrollee may be responsible for submitting invoices for payment or reimbursement;
- the enrollee may be billed for amounts above Usual and Reasonable payments and for services which are not medically necessary;
- Anthem has not credentialed these providers.

Utilization Management

For both levels of benefit, In-Network and Out-of-Network, services must comply with the Utilization Management procedures described in this section in order to be eligible for coverage.

Covered Charges

The covered charges for this Plan are those charges up to the network fee schedule, or Usual & Reasonable (U&R) reimbursement for non-network providers. Network providers accept Anthem's network fee schedule as payment in full and the member is not responsible for any "balance billing." In the case of non-network provider charges, the member is responsible for balance billing for charges above U&R. Covered charges are reduced by 50% for inpatient admissions that are not precertified.

Deductible

Unless otherwise stated, all health care benefits are subject to a calendar year benefit period and, in the case of out-of-network services, a deductible. Benefits are paid according to the date the service was provided, not the date the claim is filed.

Plan deductibles:

In-Network:	No plan deductible.
Out-of-Network:	$300 per enrollee, no family maximum deductible.

Deductible means the specified dollar amount of covered charges that must be incurred by each enrollee before Anthem, on behalf of Indiana University, will begin to pay benefits for the remainder of the calendar year.

The Plan deductible period is: calendar year.

If, in any calendar year, no benefits are paid because of the deductible (based on date of service), expenses incurred during the last three months of the deductible period will also be applied to the next year's deductible.

If two or more family members who are covered under this Plan are injured in the same accident, only one deductible will apply to charges related to that accident.

Copays

Fixed Dollar Copays

Certain services are subject to fixed dollar copays. These fixed dollar copays do not apply to the annual Medical Copayment Maximum.

In-Network or Out-of-Network

Office Visit Copay	$15
Therapy Visit Copay	$15
Inpatient Admission Copay	$250
Outpatient Surgery Copay	$100
Chiropractic/Osteopathic Manipulation Copay	$20
Emergency Room Copay (waived if admitted within 24 hours)	$50
Urgent Care Facility Copay	$25

Medical (Percent) Copay

Covered charges are subject to a percent copayment. In the cases of services that are subject to a fixed dollar copay, the percent copayment applies to the remaining charges after the fixed dollar copay is taken. The percent copay applies to an annual Medical Copayment Maximum.

In-Network:	10% up to the Medical Copay Maximum
Out-of-Network:	30% up to the Medical Copay Maximum

Medical Copay Maximum

In-Network:	$1,000 ($2,000 family*), then there is no copay.
Out-of-Network:	$3,000 ($6,000 family*), then there is no copay.

* No family member may contribute more than $1,000 to the In-Network family maximum or $3,000 to the Out-of-Network family maximum.

Charges that do not apply to the Medical Copay Maximum are:

- Out-of-Network deductible;
- fixed dollar copays (office visit, inpatient, outpatient surgery, therapy visit, emergency room and urgent care facility copays);
- non-network provider charges above Usual & Reasonable (U&R)
- adjustments to covered charges for inpatient admissions that were not precertified;
- covered charges for prescription drugs or mental health/chemical dependency.

UTILIZATION MANAGEMENT

Utilization Management is a program designed to ensure medically necessary, quality services to enrollees in the most appropriate and cost effective setting. This is achieved through PREADMISSION CERTIFICATION of inpatient services and INDIVIDUAL PATIENT CASE MANAGEMENT.

Preadmission Certification

Medical consultants selected by Anthem must review and certify all proposed inpatient hospital care. A newborn remaining in the hospital after the mother's discharge must have those additional days certified. The enrollee must call for precertification anytime he or she is admitted to a hospital. (See the Plan identification card for the applicable telephone number.)

EXCEPTION: If Medicare is the enrollee's primary coverage, precertification does not apply.

The enrollee or the enrollee's physician must contact the Anthem medical consultants as follows:

1. Maternity care: within one working day after admission.

   *In the event the individual delivering a member's child is not covered by this Plan, it should be noted that all precertification and utilization review procedures of this Plan must be followed for Plan coverages of that newborn.

2. Emergency care: within two working days after admission.

3. All other medical and surgical:
   a. by mail at least 14 working days before admission.
   b. by phone at least two working days before admission.

Anthem's medical consultants will review the case with the enrollee's physician and determine how long the enrollee needs to stay in the hospital. If they find that the enrollee can be treated as an outpatient, the admission will not be certified. At the time preadmission certification is requested, the medical consultants will request information about required tests. They will not certify extra inpatient days for tests that the enrollee can obtain on an outpatient basis prior to the inpatient admission.

The medical consultants will respond to requests for certification as follows:

1. within two working days for requests received by mail;

   or

2. within one working day for requests received by phone.

After admission to the hospital, the medical consultants will continue to work with the enrollee's physician and monitor medical progress. If the enrollee needs to stay longer than was first thought, additional days must be certified.

Precertification and/or prior authorization certifies medical necessity for an inpatient setting and length of stay, but does not necessarily determine plan coverage.

If the enrollee's admission is not precertified:

1. Covered charges for that portion of the room and board, x-rays, laboratory tests, and drugs that were not precertified will be reduced by 50%.
2. The deductible, if applicable, will be subtracted from that amount.
3. Any copayment provisions of the Plan will then be applied.

NOTE: This Plan provides no coverage for days determined to be not medically necessary. The enrollee is responsible for any amounts which were not paid because of item "1" of this section and these amounts will not apply to any deductible or copayment maximum.

Appeal

If an admission is not precertified, the enrollee or the enrollee's physician may submit additional information to the medical consultants and request a review of the case.

Individual Patient Care Management

Care management relates to the monitoring of quality and provides early identification and assistance with complex and chronic health care needs. Care management is coordinated by a licensed nurse case manager who works in conjunction with a staff that consists of licensed nurses, physician consultants and other clinically trained professionals. There are two components of Care Management: (1) identification and early intervention in complex, potentially catastrophic cases, and (2) identification of chronic medical conditions that can benefit from active participation by the patient in monitoring and managing their health.

The care management process for catastrophic cases may include the development and implementation of a cost-effective alternative to inpatient hospital stays. Examples of less costly alternative care are: skilled nursing facility services, home health care, home antibiotic IV therapy, or hospice care and special medical equipment, such as ventilators or respirators. Coverage will be provided for the less costly alternative even if such care is not specifically stated as a covered benefit under the Plan. Such care will be subject to the same plan maximum, deductibles and copayment requirements as the care that is replaced.

Care management of chronic medical conditions, such as asthma and diabetes, includes providing health information to the patient and identifying ways to help the patient to better manage their health. Working together with the nurse care manager, the patient can obtain support for decisions related to medications, exercise, diet, etc., that can assist in achieving and maintaining good health.

EXCEPTIONS TO OUT-OF-NETWORK BENEFIT LEVELS

There are times when Out-of-Network benefits levels do not apply. The following services are provided as In-Network benefits:

- Initial treatment by any provider for either a traumatic accidental injury within 48 hours of the accident or for an emergency illness within 24 hours of the onset of symptoms. Initial treatment is care required to evaluate and stabilize an individual in an emergency.

- Services for enrollees whose primary coverage is with Medicare.
- Services when the enrollee lives outside of Indiana and in excess of 30 miles from a preferred provider.
- Emergency or urgent care services for college/university/boarding school students attending a school located outside of Indiana.
- Referrals by a preferred network provider to a non-participating provider when the non-participating provider services are, in Anthem's judgment, not reasonably available within the preferred provider networks.
- Services provided by a non-network radiologist, pathologist or anesthesiologist when the enrollee receives services at an in-network hospital.

NOTE: In all cases, inpatient services need to be pre-certified by Anthem's Utilization Management for any benefit coverage (see page 25) and covered charges are limited to Usual and Reasonable (U&R) allowances.

For MENTAL HEALTH/CHEMICAL DEPENDENCY, PRESCRIPTION DRUG, and ORGAN AND TISSUE TRANSPLANT services, enrollees must comply with network guidelines described in the corresponding sections of this booklet.

MEDICAL BENEFITS SUMMARY

Plan coverages will not be provided for the following:

- Treatment that is not medically necessary.
- In the event that the enrollee leaves the hospital against medical advice or against the advice of the treating health care provider
- The enrollee chooses a treatment alternative that is more intense than is necessary based on the medical condition or symptoms.
- The enrollee incurs additional costs and requires additional services as a result of ignoring or disregarding the medical advice or treatment plan of a treating health care provider.

See other *EXCLUSIONS* under Section F.

MEDICAL COVERAGE:

Ambulance

Covered services — must be provided by a hospital or by a government certified ambulance service. The vehicle must be designed and equipped to transport the sick and injured. Both air and ground services are covered.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

LIMIT: Professional air or surface ambulance services, whichever is medically necessary, to or from the nearest hospital where the needed care is available, is covered if:

1. the enrollee is admitted as an inpatient;
2. the enrollee receives outpatient emergency accident care; or
3. the enrollee receives outpatient emergency illness care.

Eligible charges are limited to:

1. the U&R allowance per ground (surface) trip; or
2. $2,500 per air trip.

Payment will be limited to charges for the medically necessary type of surface ambulance to the nearest hospital, if:

1. air ambulance is used when not medically necessary;
2. the enrollee is taken to a hospital which is not the nearest one providing the care needed; or
3. a more intensive type of surface ambulance service is used when not medically necessary.

Anesthesia

Covered services — general and regional anesthesia when it is medically necessary that the service be performed by a provider individual other than the surgeon or assistant surgeon.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

Blood

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

Chiropractic Services

See Neuromuscular Manipulations

Consultations

Inpatient, Outpatient, Home, and Office

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

Corneal Transplant

Corneal Transplants are paid under the medical rather than the transplant coverage component.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

Dental, Accidental

Covered services — repair or replacement of injured sound natural teeth to return the tooth to its pre-accident functional state is covered when:

- the services are required as a result of accidental, traumatic injury;
- care is sought within 48 hours after the accidental injury;
- the services are started within sixty (60) days and completed within one year from the date of the accident.

A traumatic injury is defined as injury to living tissue caused by an extrinsic force. Injury caused by chewing food or grinding teeth (bruxism) is not covered. Sound natural tooth is defined as one which is free of active or chronic decay, has at least 50% bony support, is functional in the arch, and is not excessively weakened by multiple dental procedures. When more than one treatment alternative is available, the Plan will pay for the less costly treatment. Coverage includes any natural tooth whether filled, capped, or crowned which meets the criteria, but excludes artificial teeth or pontics which are part of dentures or bridges. When injury necessitates replacement of an existing bridge because of the loss of natural teeth which serve to anchor the bridge, benefits for only the expense of the anchor teeth (as if there had been no bridge at the time of the injury) will be provided.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

Diabetes Self-Management Training

Self-management training is covered when 1) medically necessary, and 2) prescribed in writing by a physician or podiatrist, and 3) provided by a health care professional qualified under state law and who has been certified by the American Diabetes Association. Training is limited to: one visit after the initial diagnosis is made; one visit per calendar year when a change in self-management is medically necessary due to a diagnosis that represents a significant change in the condition; one visit per year for re-education. Each covered visit is limited to one session of not more than three hours.

Emergency Accident or Illness

Benefits paid — subject to the Plan provisions, the Plan deductible, and to the emergency room deductible; 90% of covered charges for outpatient emergency services.

An emergency accident is a sudden external event resulting in bodily injury. An emergency illness is one that is characterized by the sudden unexpected onset of acute symptoms. In order to be qualified as an emergency, accidents or illnesses must be of such severity 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 result in:

1. permanently jeopardizing the enrollee's health;
2. serious medical consequences;
3. serious impairment of bodily function; or
4. serious and permanent dysfunction of any bodily organ or part.

Covered services — facility and physician services to treat emergency accidents and illness.

Home And Office Calls

Covered services — services rendered in the physician's office or in the enrollee's home.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

Home Health Care

Covered services — non-custodial medical and nursing care when:

1. the enrollee has been referred to a home health care agency by a physician; and
2. the provider of service is not a member of the enrollee's immediate family.

NOTE: Home health aides are not covered.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

Covered charges for home IV therapy drugs are limited to the average wholesale price.

Enteral feeding formulas that substitute for normal nutrition are not covered.

Maximum amount payable — $5,000 per enrollee, per calendar year.

Hospice

Hospice care is covered when arranged and approved through Anthem Case Management. Services are covered when all the following criteria are met:

1) The hospice care is provided by a dully licensed hospice agency and/or facility;
2) The medical diagnosis projects a life expectancy of six months or less, if the disease follows its normal course;
3) The patient and family agree that symptom and pain management, rather than curative treatment, are the goals of care;
4) The care is ordered by and provided under the direction of a Physician;
5) A full-time care giver is available in the home.

Covered services may include:

1) Room and board for confinement in an inpatient hospice setting when an inpatient setting is determined to be medically necessary by Anthem Case Management;

2) Services in the home, including:
   - skilled nursing visits;
   - non-skilled nursing services under the supervision of a registered nurse;
   - home health aid services;
   - medical supplies and Durable Medical Equipment;
   - prescription drugs;
   - counseling services for the employee's immediate family by a Social Worker or a licensed pastoral counselor (if such licenses are required in the state in which the services are provided);
   - other services may be provided as an all-inclusive per diem hospice reimbursement.

NOTE: Bereavement counseling following the death of the patient may be provided through the benefits of the IU Employee Assistance Program.

Benefits paid —	In-Network:	90% of covered charges.
	Out-of-Network:	70% of covered charges.

Hospital Inpatient

Room and Board

Semiprivate room, specialty care visits, ancillary services and supplies provided and billed by the hospital —

Benefits paid —	In-Network:	90% of covered charges.
	Out-of-Network:	70% of covered charges.

Private room — covered charges are the average semiprivate room rate. If medically necessary or if the hospital has private rooms only, a private room is covered at U&R reimbursement.

Preadmission Testing

Covered services are necessary tests and studies performed in an outpatient setting before an inpatient hospital admission.

Services are not covered if:

1. performed to establish a diagnosis;
2. repeated after the enrollee is admitted;
3. performed more than 72 hours before the enrollee is admitted; or
4. the enrollee cancels or postpones the admission.

Inpatient Medical Visits

A surgeon's visits are included with the surgery fee and are covered under the surgery benefit.

Covered services — medically necessary physician visits while the enrollee is an inpatient in a provider facility.

Benefits paid —	In-Network:	90% of covered charges.
	Out-of-Network:	70% of covered charges.

Mastectomy Services

This Plan complies with the Women's Health and Cancer Rights Act of 1998.
Covered services related to mastectomy:

- Reconstruction of the breast(s) on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis (and necessary replacements) and physical complications related to all stages of mastectomy, including lymphedemas.

Maternity

Maternity benefits — the same as for any other medical condition.

NOTE: The enrollee or the enrollee's physician must call medical consultants used by Anthem within one working day after a maternity admission. Additional days must be certified if a newborn remains in the hospital after the mother's discharge.

See the Utilization Management section of this booklet for more information about certifying inpatient admissions.

NOTE: The employee must add the newborn to Plan coverage within 60 days of birth. Payment of claims within the first 31 days does not mean the newborn has been added. Precertification of the maternity admission does not add the baby. A Change in Status Form and new Health Plan Enrollment form must be received by the campus HR office within 60 days of the admission. Please contact a campus Human Resources office to obtain the appropriate forms.

Covered services for maternity include the newborn's routine nursery care.

Medical Aids

Medical Aids include prosthetic and orthotic appliances, durable medical equipment, and medical supplies.

Providers of Medical Aids are "exempt" providers in the Anthem PPN network. Anthem does not maintain network contracts for these services, so covered charges in this category are paid at the In-Network benefit level. Covered charges are limited to Usual & Reasonable (U&R).

Benefits paid — 90% of covered charges.

Prosthetic Devices

Covered services — initial purchase, fitting, repair, and replacement of fitted devices which replace body parts or perform bodily functions. Benefits include initial purchase only of 1 wig in the event of total hair loss related to chemo or radiation therapy. Benefits include prostheses related to mastectomy including 2 prescription mastectomy bras per year.

Durable Medical Equipment

Covered services — rental, initial purchase, repair, and replacement of equipment that is appropriate for home use and is made mainly to treat the ill or injured.

Routine maintenance is not covered. Covered charges for deluxe items are limited to the cost of standard items. Covered charges for rental are limited to the purchase price of the equipment.

Orthotic Appliances

Covered services — initial purchase, fitting, repair, and replacement of braces, splints, and other appliances used to support or restrain a weak or deformed body part.

NOTE: Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace, standard elastic stockings, garter belts, and other supplies not specially made and fitted are not covered.

Medical Supplies

Covered services — Medically necessary home blood monitoring equipment machines and ostomy supplies.

Mental Health and Chemical Dependency

See Section D for a description of plan coverages.

Neuromuscular Manipulations

Covered services — all manipulations and related supplies, drugs, and therapy provided by or under the supervision of a chiropractor or osteopathic physician.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

There is a $20 copay per visit. Medically necessary care shall be therapeutic care for acute problems, including traumatic or acute exacerbations or chronic problems. Care that is to maintain a body function at a given plateau through periodic adjustments and care that does not provide a cure for a condition causing a patient discomfort is not covered by this Plan.

LIMIT: Up to 15 visits per enrollee, per calendar year. This includes visits when charges are applied toward the Plan deductible.

Maximum amounts payable:

$150 for diagnostic services performed or prescribed in conjunction with neuromuscular manipulations, per enrollee, per calendar year.

Newborn Care

See Maternity

Outpatient Diagnostic Services

Non-invasive diagnostic services provided in a physician's office or outpatient facility.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

NOTE: Unless otherwise provided, the enrollee's medical benefits do not include the following services:

1. audiometric testing (when performed to determine the need for a hearing aid);
2. eye refractions;
3. examinations for the fitting of eyeglasses, contact lenses, or hearing aids;
4. dental examinations;

5. premarital examinations;
6. research studies, screening examinations, physical examinations, or check-ups, other than those described under well child care and well person care;
7. screening tests that do not meet medical necessity guidelines.

Facility charges for invasive diagnostic procedures, for example, colonoscopies and cardiac catheterizations are covered under the surgery benefit.

Prescription Drugs

See Section C — Prescription Drug Coverage for complete information on Prescription Drug coverage.

Skilled Nursing Facility

Skilled Nursing Facility admissions are covered when medically necessary as determined by the Plan Administrator. In general, skilled nursing facility care is medically necessary when the services required for treatment of sickness or injury are so inherently complex, or the clinical condition of the enrollee is such that services rendered can only be safely and effectively performed in an inpatient setting by, or under the direct supervision of, licensed professional personnel with special medical skills or training.

Covered services include room, board, and ancillary services.

Benefits paid —	In-Network:	90% of covered charges.
	Out-of-Network:	70% of covered charges.

Limitations:

- The fact that services are prescribed by a physician and provided in a Skilled Nursing Facility, of itself, does not make the services medically necessary.
- Custodial Care is not covered.
- Covered charges for a private room are limited to the average semiprivate Skilled Nursing Facility room rate.

Surgery

Facility Surgery Services

Inpatient and Outpatient facility services are subject to fixed dollar copays:

Inpatient:	$250 per inpatient admission.
Outpatient:	$100 per surgical session.

Remaining facility services are subject to the Medical Copay:

Benefits paid —	In-Network:	90% of covered charges.
	Out-of-Network:	70% of covered charges.

Professional Surgery Services

Physician's surgery services are subject to the Medical Copay.

Benefits paid —	In-Network:	90% of covered charges.
	Out-of-Network:	70% of covered charges.

Limitations:

- If more than one surgical procedure is performed during one session, full benefits will be paid for the primary surgical procedure. Benefits for other surgical procedure(s) during the same operative session will be paid at 50% of covered charges.
- Incidental procedures are not covered.
- Medical necessity of an assistant surgeon is determined by the Plan Administrator. Covered charges for an assistant surgeon are limited to no more than 20% of the covered surgical allowance.
- Cosmetic surgery is not covered. Since some surgical procedures can be performed for either reconstructive or cosmetic purposes, the Plan Administrator will review related medical documentation to determine the primary purpose of the surgery.
- Reconstructive surgery is covered when determined by the Plan Administrator to be Medically Necessary to correct a deformity resulting from a previous therapeutic process or to correct a documented functional impairment caused by trauma, congenital anomaly, or disease.
- Psychological reasons, in the absence of functional impairment or deformity, are not sufficient to constitute medical necessity. However, reconstructive surgery related to mastectomy is covered including reduction mammoplasty when performed in a contralateral breast following mastectomy when it is otherwise impossible to achieve a reasonable degree of symmetry in restructuring the mastectomy site.

Temporomandibular Joint (TMJ) Syndrome

Benefits paid —	In-Network:	90% of covered charges.
	Out-of-Network:	70% of covered charges.

Orthodontia for treatment of TMJ is not a covered benefit.

Therapy Services

Therapy services are medically prescribed treatment concerned with improving, adapting, or restoring functions which have been impaired or permanently lost as a result of illness or injury (or congenital abnormality)to improve the patient's ability to perform those tasks required for independent functioning. Therapy services must be medically necessary as determined by the Plan Administrator. The fact that any particular Physician may prescribe, order, recommend, or approve therapy does not, of itself, make such treatment a covered benefit.

When Medically Necessary, the following therapies are covered:

Occupational Therapy — the use of therapeutic activity designed to improve or restore functions which have been impaired due to congenital disability, illness, or injury; or, where the function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.

NOTE: Prior to receiving cardiac rehabilitation services, contact Anthem's IU Service Center for predetermination of coverage.

Orthoptic Pleoptic Therapy — the treatment of an abnormal condition such as strabismus by visual training exercises.

NOTE: Prior to receiving treatment, contact Anthem's IU Service Center for predetermination of coverage.

Physical Therapy — the use of physical measures, activities and devices, designed to reduce the incidence and severity of physical disability, bodily malfunction and pain.

Respiratory/Inhalation Therapy — the introduction of dry or moist gases into the lungs for treatment purposes.

Speech Therapy — treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies or previous therapeutic processes.

Criteria for coverage of therapy services include, but are not limited to, the following:

- The patient's condition or the therapy services must be of such a level of complexity that the services can only be effectively performed by a qualified therapist.
- The services must be part of a written treatment plan that is specific, goal-directed, and that involves generally accepted modalities which are consistent with the patient's current and potential level of function.
- There must be an expectation that the services will produce significant practical improvement in the patient's level of functioning within a reasonable and generally predictable time frame (usually 90 days or less) and that the expected improvement in functioning could not be accomplished in the absence of therapy.
- For continuing therapy, there must be evidence that significant practical improvement in the patient's condition is occurring as a result of therapy.

Therapy Services (cont'd.)

Excluded therapy services include, but are not limited to:

- Therapy to improve function that could reasonably be expected to improve as the individual gradually resumes normal activity, or could reasonably be expected to improve as a child develops.
- Therapy related to activities for the general good and welfare of patients, e.g., general exercise to promote overall fitness and flexibility; diversional, recreational, vocational therapies; therapy to improve a patient's motivation; behavior modification and training; development of social skills or coping skills; or therapy that is primarily educational in nature.
- Therapy for which the expected improvement potential would be insignificant in relation to the extent and duration of the services required to achieve such potential.
- Therapy for language training for educational, psychological or developmental speech delays.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

Well Child Care

Covered services:

1. The initial routine newborn examination following delivery when performed in a hospital by a physician other than the delivering physician.
2. Subsequent routine visits by a physician to the newborn, until the newborn is released from the hospital.
3. Immunizations, office visits, TB tine tests, and urinalysis, until the child reaches 8 years of age.

NOTE: Immunizations and office visits for school, camp, travel and sports are not covered.

Well Person Care

Covered services — all routine services, including immunizations, physical examinations, screening tests.

Benefits paid — In-Network: 90% of covered charges.
Out-of-Network: 70% of covered charges.

Maximum amount payable for enrollees age 8 or older — $200 per enrollee, per plan year.

NOTE: Routine services, including immunizations and physical examinations required for sports, school, camp, employment, marriage, or travel are not covered.

The fact that a screening test has been prescribed by a physician does not, of itself, make such test a covered benefit.

EXCLUSIONS

See *EXCLUSIONS* under Section F.

SECTION C - PRESCRIPTION DRUG COVERAGE

The principal features of the PRESCRIPTION DRUG COMPONENT of the IU PPO-Plus Health Care Plan are described in this section.

- The preferred provider network for prescription drug benefits is as follows: CVS and Osco retail pharmacies (the Osco store chain includes Albertson's, Jewel, Sav-On, and Lucky's pharmacies) and Continental Pharmacy mail order. (Other retail entities may be considered if a significant number of enrollees in Indiana, Illinois, Ohio or Kentucky do not have access to a "preferred provider" within a 15 mile radius of their residences.)

- The prescription drug component of the Plan provides coverage at two levels of benefits: In-Network benefits when the preferred network is used and Out-of-Network benefits when prescriptions are filled at non-network pharmacies.

- Covered charges for brand name drugs are subject to Average Generic Pricing, regardless of the reason the brand is prescribed.

Covered services: FDA-approved drugs requiring a prescription under federal law which are prescribed for a diagnosis covered by the Plan and consistent with Plan Utilization Management principles; insulin, insulin syringes, test strips, and lancets.

Covered Charges: If there is an FDA Class A-rated generic drug available for a prescribed brand, covered charges are limited to the average generic drug cost. This rule applies even if the enrollee's physician prescribes a brand name drug.

In-Network

4-Tier Prescription Drug Copay Schedule

		Participant Copays:	
		Retail Up to a 30-day supply	**Mail** Up to a 90-day supply
Tier 1	**Generic Drug or Brand with Generic Equivalent***	$5	$10
Tier 2	**Brand drug, low cost****	$10	$20
Tier 3	**Brand drug, high cost*****	$25	$50
Tier 4	**Non-covered drugs with plan's discount********	100%	100%

(The copay amount should not exceed the cost of the prescription plus any filling fees.)

* Employee pays the difference between brand and generic, in addition to the generic copay.

** 'Low cost' refers to prescriptions up to $60 retail for up to a 30-day supply (up to $180 mail order for up to a 90-day supply).

*** 'High cost' refers to prescriptions $60 or more for up to a 30-day supply ($180 or more mail order for up to a 90-day supply).

**** Tier 4 includes drugs which require a prescription by law, but are not covered under the Plan, for example, Viagra and drugs for weight loss or hair loss. The employee receives the benefit of the Plan's discount, but pays 100% of the discounted price of the prescription.

Out-of-Network

Prescriptions not filled through either the Continental Pharmacy mail order facility or the retail pharmacy network are paid through Scrip Pharmacy Solutions at 50% of covered charges. Claims must be submitted within one year of the date the prescription was filled.

NOTE: Prescriptions that are filled through the Continental mail order facility will be filled with generic prescription drugs, unless the prescribing physician communicates to the pharmacist that generic prescription drugs are not to be used for a particular prescription by handwriting the words "dispense as written" or "brand necessary" on the prescription.

LIMITATIONS

The following prescription drugs are only covered when medically necessary for treatment of a medical condition:

- Tretinoin (Retin A) prescribed for enrollees over age 29;
- Birth control drugs (birth control drugs prescribed for contraception are an exclusion under this benefit plan);
- Vitamins requiring a prescription (over-the-counter prescriptions are not covered).
- Lupron

The enrollee's physician must provide a statement indicating the medical condition for which the drug is being prescribed and that the drug is not being prescribed for cosmetic purposes, birth control, infertility or preventive maintenance. A new physician statement is required each benefit year. The physician statement, *including the enrollee's name and social security number, the prescription information, and the specific medical condition requiring the prescription*, should be mailed or faxed to Scrip Pharmacy Solutions:

Scrip Pharmacy Solutions
Attention: IU Account Manager
33 North Road
Wakefield, RI 02879
FAX: 888-299-5316

When having these limited coverage prescriptions filled through the Continental Pharmacy mail order facility, enclose a copy of the physician's statement along with your prescription.

For quality and safety concerns, the Plan may limit the amount of drug that is covered as a 30-day (or 90-day) supply. These limits are based on package inserts provided by the manufacturer and on current clinical literature.

Insulin syringes, test strips and lancets are available under the prescription drug benefit. Blood glucose monitoring equipment and ostomy supplies are paid under the medical benefits described in the medical benefit component of the Plan.

Covered charges for home IV therapy drugs are limited to the average wholesale price.

Compounded drugs with at least one covered prescription drug in an effective dosage are covered when the prescription drug(s) are in a FDA-approved dosage form prior to being compounded.

MAIL ORDER PRESCRIPTION SERVICE

Mail order prescriptions can be initiated in one of four ways:

1. The enrollee or physician may call 800-677-4323 to request the transfer of a prescription or to call in a new prescription; or

2. The physician may fax a new prescription to 800-205-7408; or

3. The enrollee may mail a new prescription in the envelope provided in the Continental Pharmacy mail order brochure; or

4. The enrollee may use the IU Prescription Benefit website; access is through the University Benefits Office website at: *www.indiana.edu/~ubenefit*.

Brochures are available at the University Benefits Office website: *www.indiana.edu/~ubenefit/* or by calling Continental Pharmacy.

Please allow 14 days for processing and delivery of a prescription.

SUBMITTING CLAIMS FOR OUT-OF-POCKET PRESCRIPTION EXPENSES

Prescriptions filled at In-Network pharmacies:

For prescriptions which are paid by the enrollee (for example, a newly hired employee or added dependent before enrollment has been processed):

- The enrollee may return to the store within 7 days for cash reimbursement; or

- If more than 7 days has elapsed, prescription receipts may be submitted to Scrip Pharmacy Solutions for reimbursement at the in-network level. See Section G for claim procedures.

Prescriptions filled at Out-of-Network pharmacies:

- When an enrollee has prescriptions filled at an Out-of-Network pharmacy, prescription receipts may be submitted to Scrip Pharmacy Solutions for reimbursement at the out-of-network level. See Section G for claim procedures.

EXCLUSIONS

See *EXCLUSIONS* under Section F.

SECTION D — MENTAL HEALTH/CHEMICAL DEPENDENCY COVERAGE

The principal features of the MENTAL HEALTH / CHEMICAL DEPENDENCY component of the IU PPO-Plus Health Care Plan are described in this section.

COVERED PROVIDERS

Indiana University Psychiatric Management (IUPM) is a managed care system for mental health and chemical dependency treatment utilizing a defined network of preferred providers.

Services must be provided by Covered Providers in order to be a covered benefit under this Plan.

Covered Professional Providers include licensed psychiatrists, addictionologists, clinical psychologists, master's level practitioners licensed at the LCSW, LMFT, or LMHC levels or master's level psychiatric nurse practitioners.

Covered Facility Providers include acute care general hospitals, acute care psychiatric and chemical dependency hospitals, community mental health centers, that are licensed and operated in accordance with the laws and regulatory agencies applicable in the state in which they are located.

Residential, educational, custodial, correctional, or long-term treatment facilities are not Covered Providers.

PROVIDER NETWORK

IUPM contracts with a comprehensive, defined network of acute care mental health and chemical dependency treatment providers who have been credentialed by IUPM.

In-Network Benefits: Full benefits are provided when services are authorized by IUPM and provided within the IUPM network of Covered Providers.

Out-of-Network Benefits: Partial benefits are provided when services are authorized by IUPM and received from out-of-network Covered Providers.

No services are covered, except for a single assessment visit to a Covered Provider, without authorization by IUPM. Enrollees may make an initial appointment with an In-Network or Out-of-Network Covered Provider who must contact IUPM Case Management after the first assessment visit to obtain prior approval for any further care.

IUPM CASE MANAGEMENT

Case Management of IUPM must authorize treatment for any coverage under this plan, for both In-Network and Out-of-Network benefits. Enrollees may make an initial evaluation appointment with an In-Network or Out-of-Network Covered Provider who must contact IUPM Case Management after the first assessment visit to obtain prior approval for any further care. Case management and referral services may be accessed by calling IUPM at 800-230-4876 on a twenty-four hour a day basis.

Enrollees may contact IUPM for the following assistance:

- Verify the network status of mental health or chemical dependency clinicians or programs.
- Obtain assistance in securing immediate access for assessment in the event of a crisis or urgent situation.
- Assistance with locating a network Covered Provider with a specific specialty, in a specific geographic area, or with fluency in a specific language, sign language, ethnic, or gender experience.
- Securing approval for proposed care.
- Obtaining information on the IUPM program, Covered Providers, protocols, or claim status.

IUPM will follow up on all mental healthcare/chemical dependency services to assure rapid assessment and goal-directed treatment; and attempts will be directed toward utilization of appropriate levels of care across a broad continuum of services. IUPM will also focus on a process of continuous quality improvement to ensure that the care delivered to enrollees is prompt, courteous, appropriate, and efficient.

All patient inquiries and treatment information are maintained in a strictly confidential manner. Under all circumstances, related individual patient information is protected so that there is neither direct nor indirect access to such information by supervisors/managers or other individuals involved in employment activities.

COVERED SERVICES

Services covered under this benefit include acute care for a Mental Health Condition as listed below:

- Services that are medically necessary as determined by IUPM;
- Inpatient care or partial hospitalization received from Covered Providers for diagnosis, crisis intervention, and short-term treatment for mental illness, and detoxification and rehabilitation for chemical dependency (Inpatient care is only covered to the extent that is needed to stabilize the patient); and
- Outpatient care received from Covered Providers for the diagnosis, crisis intervention, and short-term treatment for mental illness, and for detoxification and/or rehabilitation of alcoholism or substance abuse.

A Mental Health Condition is a condition identified as a mental disorder in the most current edition of the Diagnostic and Statistical Manual of Mental Conditions or the American Psychiatric Association.

COPAYS AND DEDUCTIBLES

The Mental Health/Chemical Dependency coverages in this Section are administered separately from the MEDICAL benefits of this Plan, and, for this reason, MEDICAL deductibles, copays, and copay maximums do not apply to the benefits in this Section. The copays and deductibles specific to this Section are listed in the "Overview of Mental Health/Chemical Dependency Coverage" that follows.

EMERGENCY AND OUT-OF-THE-AREA SERVICES

IUPM has clinicians on call 24 hours a day, available to assist with emergencies or to authorize urgent care, by calling **800-230-4876.**

In the event of an emergency illness, enrollees should obtain care from the nearest qualified mental health provider who should then contact IUPM's 24 hour emergency on-call service at 800-230-4876 to obtain approval, but no later than 24 hours after the initial care. (Contact with IUPM should be initiated by the treating provider.) After the initial provider service, IUPM must authorize all treatment for any coverage under this Plan. The initial emergency treatment will be treated as In-Network plan coverage.

An emergency illness is a medical or psychiatric condition that is characterized by the sudden onset of acute symptoms of such severity that the absence of immediate medical or psychiatric attention may result in acute danger to the participant, harm to others, or which places the participant at acute risk of disability.

Enrollees who live or are temporarily out of the area should contact IUPM Case Management Services for referrals to providers. IUPM will have network association agreements with providers outside of the Indiana area. In the event that there is no network association provider near the participant, IUPM will provide assistance in locating a qualified provider from the local community. (Note that IUPM must authorize treatment for any coverage under this Plan.)

EXCLUSIONS

Services not covered under this benefit include, but are not limited to, the following:

Services that are not medically necessary as determined by IUPM.

Treatment that is experimental/investigational or of unproven efficacy as determined by the IUPM, including, but not limited to: psycho surgery, megavitamin therapy, insulin shock therapy, sexual surrogate therapy, nutritionally based therapies for alcoholism and chemical dependency, and most forms of aversion therapy.

Services for Chronic Conditions except acute exacerbation of the condition.

Services related to long term psychotherapy focusing on self growth, family of origin issues and analytical therapies.

Services which according to generally accepted professional standards are not amenable to favorable modification through short term treatment.

Therapy for which the expected improvement potential would be insignificant in relation to the extent and duration of the services required to achieve such potential, Treatment is covered when it focuses on identified, short term attainable goals to stabilize patient.

Therapies offered or performed as part of a residential, school or long term treatment facility or long term psychiatric management in any institutional or home-based setting. This includes therapies in correctional environments.

Care for management of disruptive behaviors and other behavioral disorders beyond acute stabilization for danger to self or others.

Therapy services related to activities for the general good and welfare of patients, e.g. diversional, recreational, vocational, or to improve patient's motivation, behavior modification and training; development of social skills, interpersonal skills, or coping skills; or therapy that is primarily educational in nature.

Sex therapy and sex counseling.

Treatment of sexual offenders or perpetrators of sexual or physical violence.

Marriage counseling or relationship counseling except as specifically stated as covered in this Section.

Mental Retardation and the behavior resulting from mental retardation, learning disorders and disabilities, motor skills disorders, communication disorders, feeding and eating disorders of infancy or early childhood, tic disorders, elimination disorders, and minimal brain dysfunction.

Selective mutism, attachment disorders, movement disorders.

Delirium, dementia, amnestic and other cognitive disorders beyond initial assessment and diagnosis, and behaviors resulting from these disorders.

Developmental testing for educational, intellectual, fine and gross motor or speech evaluation.

Treatment for specific phobias that do not significantly impact the patient's ability to function.

Pain management.

Impulse control disorders and intermittent explosive disorder.

Disruptive behavior disorders including, but not limited to oppositional defiant disorder, conduct disorders, adult, child or adolescent antisocial behavior. Behavioral training for conduct problems, defiant behavior and disruptive behavior.

Acupuncture, hypnosis, biofeedback, and EMDR (eye movement desensitization).

Nicotine addiction, caffeine dependency, obesity, or weight control.

Services provided under V-Code "diagnoses."

Services beyond the point that the member refuses to accept or cooperate with recommended treatment and has been so advised and still refuses to accept the recommended treatment.

Custodial care, including care for degenerative or organic dementia, hospitalization to prevent runaway, and involuntary detention of individuals accused of felonies in the absence of a diagnosable mental disorder excluding antisocial personality disorder.

Behavioral disorders from mental disorders due to general medical conditions, psychological factors affecting medical conditions, somatoform disorders, factitious disorders, malingering, dissociative disorders, paraphilias, sleep disorders, sexual disorders and gender identity disorders.

Personality disorders beyond danger to self and others.

Mental assessments or psychological testing as evaluation for surgery or other medical procedures.

See *EXCLUSIONS* under Section F that also apply to this benefit.

APPEALS

Decision by IUPM related to authorizations and claim payments may be appealed under the guidelines outlined in Section G of this booklet.

Overview of Mental Health and Chemical Dependency Plan Coverage

Covered Services	In-Network Provider	Out-of-Network Provider
Inpatient and Partial Inpatient Hospitalization Services	• $250 deductible per admission • 90% coverage, then 100% after the enrollee's 10% copay equals $500 per episode of treatment	• Deductible of $500 per admission • 80% coverage of the first $2,500 of Usual and Reasonable (U&R) charges • 60% coverage of Usual and Reasonable (U&R) charges over $2,500 • No Maximum copay
Outpatient Mental Health and Chemical Dependency Services • Ambulatory detoxification by a psychiatrist or addictionologist • Primary intensive chemical dependency treatment, including aftercare services, in a state licensed program (up to $2,500 per calendar year). • Services by a Covered Provider. • Marital, relationship, or family counceling by a qualified provider (up to six visits per calendar year).	• No deductible for therapy visits • $20 per visit copay • $50 Emergency Room Deductible	• No Deductible for therapy visits • $30 per visit copay • Maximum covered is $50 per visit • $50 Emergency Room Deductible

*** Out-of-Network:** Copayment amounts do not accumulate toward In-Network limits; enrollees are responsible for any charges above Usual and Reasonable (U&R) or above other coverage limits; and enrollees may have to submit claim forms. Out-of-Network providers must be Covered Providers. **Usual and Reasonable (U&R)** charges are limited to the average contracted rates for "In-Network" facilities. If an Out-of-Network facility charges more than this, the participant will be responsible for the difference.

SECTION E — ORGAN AND TISSUE TRANSPLANT COVERAGE

The principal features of the ORGAN AND TISSUE TRANSPLANT component of the IU PPO-Plus Health Care Plan are described in this section.

Covered Transplants

Benefits are provided for services related to the transplant of the following human organs/tissues:

- Bone marrow (autologous and allogenic)
- Heart
- Heart/Lung
- Lung
- Liver
- Pancreas
- Kidney
- Kidney/Pancreas

The transplant of any of these organs/tissues is a Covered Transplant only when the recipient is an individual covered under this Plan and when the transplant is approved and authorized by the Plan, in writing, in advance of the transplant.

Preferred Transplant Network

Indiana University Medical Center (IUMC)/Clarian Health is the preferred network for transplants and includes transplant programs at Indiana University Hospital, Riley Children's Hospital, and Methodist Hospital. In-Network benefits are paid when transplants are performed in an IUMC/Clarian transplant program. All transplants must be approved in advance through the Anthem Utilization Management process in order to be covered.

Transplant Phases

The transplant process is defined by four phases of services:

Phase I - *Transplant Evaluation*

This phase includes diagnostic work-ups and consultations necessary to evaluate whether the patient meets a transplant program's criteria for acceptance.

Phase II - *Pre-transplant Services*

This phase includes services from the date of acceptance into a transplant program until the day prior to the beginning of Phase III.

Phase III - *Transplantation Phase*

This phase includes covered services provided beginning with:

- The day prior to the solid organ transplant procedure through the discharge after the transplant has been complete.

- The day prior to admission for the Adult or Pediatric Allogenic bone marrow/stem cell transplant stay through the discharge after the transplant has been completed.

- The day prior to high dose chemotherapy or radiation through 35 days for outpatient Adult or Pediatric Autologous transplants.

NOTE: Services related to organ procurement/tissue harvest, storage and transportation for a Covered Transplant are included in Phase III without regard to the above time periods, so long as the recipient is covered under the Plan at the time of services and transplant.

Phase IV - *Follow-up Phase*

This phase includes services provided during the twelve (12) month period following the end of Phase III for the transplant.

Benefit Maximum

$1,000,000 per each enrollee for Phase III transplant services, across all IU-sponsored self-funded health care plans, including this Plan, IU PPO Healthcare $900 Deductible and IU Precision POS.

Benefits Paid

***Phase I, II, and IV (*Evaluation, Pre-Transplant, and Post-Transplant Follow-Up)**

These services are covered under the MEDICAL COMPONENT of the Plan subject to applicable medical copays and deductibles (In-Network or Out-of-Network, as applicable). Evaluations for more than one transplant program are covered to the extent that they are not duplicative. Pre-transplant diagnostic services that are duplicated from one transplant program to another are not covered.

Outpatient prescription drugs during Phases I, II, and IV are paid under the PHARMACY COMPONENT of this Plan subject to pharmacy deductibles and copays: In-Network pharmacy benefits are paid when prescriptions are filled through the Plan's retail or mail order network facilities. Out-of-Network Pharmacy benefits are paid when prescriptions are filled at other facilities.

Phase III

These services are covered under this TRANSPLANT COMPONENT of the Plan.

*In-Network:*100% of covered charges for transplants and related services provided by or arranged by IUMC/Clarian Health when the transplant is performed in an IUMC/Clarian transplant program. (MEDICAL COMPONENT deductibles and copays do not apply to Phase III.)

There are no Out-of-Network benefits available under this Plan, except in cases where the needed transplant service is not available at IUMC/Clarian and IUMC/Clarian refers the participant to another program. All such referrals must be prior approved through Anthem Case Management in order to be covered. The covered charges are limited to those that would have been covered if the transplant had been performed at IUMC/Clarian. The participant is also responsible for any amount above what would have been paid in travel expenses, meals, and lodging if the transplant had been performed at IUMC/Clarian.

Multiple Transplant Procedures

If a recipient requires more than one covered transplant procedure, the transplant services will be treated as follows:

1. If each transplant is due to related causes, each is considered as a separate benefit if the transplants are separated by at least 120 days.

2. If the transplants are due to related causes and the are not separated by at least 120 days, then they are considered as one benefit and the limits stated in these transplant provisions shall apply to the transplant.

Transplant Utilization Management

In order to be covered under the IU PPO-Plus Health Care Plan, all transplants must be approved in advance by Anthem Utilization Management. Anthem also provides case management service to coordinate medical and transplant services during all phases of the transplant.

When a plan participant is approved or "listed" by a transplant program, that program (in-network or out-of-network) must request prior-approval for coverage under the IU PPO-Plus Health Care Plan by supplying the appropriate written documentation and medical records to Anthem Utilization Management. Anthem will respond with a written approval or denial of transplant coverage.

Covered Services - Phase III

(Transplant services under Phases I, II, and IV are covered under the MEDICAL COMPONENT. See that section in the booklet for coverage details and Section F for exclusions.)

Covered services include those services during Phase III that are directly related to or resulting from transplantation of an organ or tissue into a recipient who is a participant in this Plan:

1. Organ procurement / tissue harvesting, donor matching, storage, transportation and preparation.

2. Preoperative, surgical and postoperative inpatient and outpatient services directly related to the transplant of a solid organ or to the reinfusion of bone marrow in connection with a covered transplant. Services include both facility and physician services.

3. Services and supplies for high dose chemotherapy and irradiation treatment when provided as part of a treatment plan that includes bone marrow transplantation.

4. Services provided to a living donor in conjunction with procurement of an organ or tissue for the transplant of that organ/tissue to an individual who is a participant in this Plan.

5. Reasonable and necessary transportation, lodging and meal costs incurred by the transplant recipient and one other individual, or two individuals if the patient is a minor:
   (a) Transportation costs to and from the IU Medical Center;
   (b) Meals and lodging expenses up to $200 per day;
   (c) All covered meals, lodging, and transportation are subject to a $10,000 maximum payment per transplant, and the $1,000,000 transplant benefit maximum.

See ***EXCLUSIONS*** under Section F.

SECTION F — EXCLUSIONS

The exclusions in this section apply to the MEDICAL, PRESCRIPTION DRUG, MENTAL HEALTH/ CHEMICAL DEPENDENCY and TRANSPLANT components of this Plan. Category headings are provided for indexing purposes and are not intended to limit the scope of the exclusions. This Plan provides no benefits for:

General Exclusions

Expenses incurred before the enrollee's coverage begins or after it ends, except as specifically stated as covered in this booklet.

Cost of additional treatment or services incurred as a result of the enrollee ignoring, disregarding, or refusing to cooperate with the medical advice or treatment plan of a treating health care provider.

Hospital expenses when the enrollee leaves the hospital against medical advice of the treating health care provider.

Charges in connection with any illness or injury of the covered person resulting from or occurring during the covered person’s commission or attempted commission of a criminal battery or felony. Claims shall be denied if the Plan Administrator has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the covered person.

Canceled or missed appointments.

Injury or illness resulting from "intentional" self-infliction.

Private duty nursing, except as specifically stated as covered in this booklet.

Service or treatment which is provided by a member of the enrollee's immediate family.

Education and training except as specifically covered for medical self-management of a disease state.

Services or supplies furnished by any person or institution acting beyond the scope of his/her/its license.

Services or supplies not specifically stated as covered.

Services or supplies to the extent that the enrollee or employee is not legally obligated to pay for them.

Stand-by charges of a physician.

Telephone consultations or treatment by phone or internet.

Charges for failure to keep a scheduled visit, or charges for completion of a claim form.

Travel, whether or not recommended by a physician; except as specifically stated as covered in the booklet.

Treatment of any illness sustained as a result of any act of war while the participant is covered by this Plan.

Dental Related Exclusions, see *Teeth and Supporting Structures*

Experimental, Investigational, or Research Related Services Exclusions

Charges for any experimental or investigational treatment, procedure, facility, equipment, drug, device, or supply.

Drugs which are not FDA-approved or not in an FDA-approved dosage form.

Services and supplies for research studies or screening examinations, except as specifically stated in the Benefits section of this booklet.

Services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received.

Hearing Related Exclusions

Hearing aids or examinations to prescribe them.

Lack-of-Medical-Necessity Related Exclusions

Treatment, services, supplies, or hospital care which, in the judgment of Anthem's or IUPM’s medical consultants, are not medically necessary for the treatment of illness, injury, diseased condition, or impairment.

Treatment that is court ordered or ordered as a condition of probation or parole, or pursuant to an administrative action of any entity when the treatment is not medically necessary.

Treatment and care connected with or incidental to treatment that is primarily intended to improve appearance including cosmetic or reconstructive surgery, when such procedures are performed to reshape normal structures of the body in order to improve the patient's appearance or self-esteem. However, benefits are provided for care and treatment intended to restore bodily functions or correct deformity resulting from disease, accidental injury, birth defects, or previous covered medical treatment.

Treatment that is more intensive than is necessary based on the medical condition or symptoms alone require.

Cosmetic surgery, services, and prescriptions.

Pain Management beyond what would commonly be necessary during the treatment of an illness or injury.

Diagnostic services in conjunction with seeking approval in more than one transplant program to the extent that such services are duplicated.

Services which are performed solely to preserve the present level of function or to prevent regression of functions for an illness, injury, or condition which is resolved or stable.

Other Liability Related Exclusions

Charges for services or supplies for occupational accidents and diseases which are or could have been paid for or would be available under the requirements of the Worker's Compensation and Disease Law.

Hospital, medical, or surgical services, supplies, or benefits to the extent that they are or could have been obtained under Medicare Part B, or to the extent they are obtained under Medicare Part A.

Hospital, medical, or surgical services, supplies or benefit to the extent that they are or could have been obtained under Medicaid.

Any illness or injury that the Secretary of Defense or the Secretary of Veterans' Affairs determines to be incurred in or aggravated by performance of service in the military.

Services or supplies received from a dental or medical department maintained by or on behalf of a mutual benefit association, labor union, trust, or similar person or group.

Services provided by any governmental agency to the extent that the enrollee is not charged for them, except as may conflict with state or federal law.

Treatment of any illness or injury sustained as a result of any act of war.

Personal Care Related Exclusions

Custodial care which consists of care given to make a person comfortable, such as assistance in dressing or eating, or other personal care; or non-curative care given to a person with a chronic condition; or repeated testing for a condition where there is no hope; or any care which is not primarily provided for its therapeutic value in the treatment of an illness. Other excluded custodial care includes:

- assistance with walking, bathing or dressing;
- transfer or positioning in bed;
- normally self-administered medication;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- using the toilet;
- enemas;
- preparation of special diets;
- supervision over medical equipment or exercises or self-administration of oral medications not requiring constant attention of trained medical personnel.

Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a physician.

Rest cures or sanitarium care including related services and supplies.

Pharmacy and Drug Related Exclusions

Over-the-counter drugs, that is, those drugs that can be legally purchased without a prescription. (This does not apply to insulin.)

Drugs not approved by the FDA or drugs found by the FDA to be ineffective.

Drugs and dosages or quantities that do not meet Plan Utilization Management guidelines.

Experimental drugs including those labeled "Caution-Limited by Federal law to Investigational Use."

Food and Drug Administration (FDA) approved drugs used for conditions not indicated as approved by the FDA, unless the drug is recognized for treatment of the indication in at least one (1) standard reference compendium, or the drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

Compounded drugs that 1) are not compounded from drugs in an FDA-approved dosage form, or 2) do not include at least one covered prescription drug in an effective dosage amount, or 3) have a therapeutically equivalent drug in a FDA-approved dosage form.

Take-home drugs from the hospital.

Drugs and immunizations required for travel.

Vitamins minerals or supplements, and enteral feeding formulas not requiring a prescription by law, even when prescribed for a medical condition.

Birth control pills when prescribed for the purpose of contraception.

Contraceptive devices.

Fertility drugs prescribed to treat infertility.

Growth hormones, except as approved and provided through BioScrips Case Management.

Prescriptions related to male or female sexual or erectile dysfunctions or inadequacies regardless of origin or cause.

Drugs prescribed for or in conjunction with procedures, services or conditions that are not covered under the health plan, including those prescribed for cosmetic purposes or weight loss.

Replacement of lost or damaged prescriptions.

That portion of a prescription obtained through a retail pharmacy that is in excess of a 30 day supply or obtained through mail order that is in excess of a 90 day supply, except as approved in advance by the Plan.

Special prescription packaging not required by the manufacturer.

Preventive Services Related Exclusions

Preventative or routine care, including physicals and any other routine or periodic examinations required by a third party, for example, those for sports, school, camp, employment, marriage or travel.

Services and supplies for immunizations except as specifically described as covered in the Medical Benefits Summary of this booklet.

Reproductive and Sexual Function Related Exclusions

Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, in vitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer. (This Plan does cover the diagnosis and corrective surgery related to infertility.)

Sterilization reversal.

Services and supplies related to sex transformation or for male or female sexual or erectile dysfunctions or inadequacies regardless of origin or cause; including sexual therapy and counseling, penile prostheses or implants or vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency and related diagnostic testing.

Teeth and Supporting Structures Related Exclusions

Dental services and supplies other than those provided for as Accidental Dental injuries and TMJ as described in the MEDICAL COVERAGE portion of this Section.

An appliance, or modification of one, if an impression was made before the enrollee was covered under this Plan; a crown, bridge, or gold restoration, for which the tooth was prepared before the enrollee was covered under this Plan, or root canal therapy if the pulp chamber was opened before the enrollee was covered under this Plan.

Charges for gold, silver, or other precious metals or gems when used as fillings, inlays, and onlays to restore diseased or accidentally broken teeth.

Dental examinations, treatment, or processes except as specifically stated as covered in this booklet.

Orthodontia services or supplies for treating TMJ syndrome.

Dental Implants, except as may be covered under Accidental Dental benefits.

Therapy and Condition Specific Exclusions

Acupuncture and biofeedback.

Cost of materials used in any occupational therapy.

Hospitalization for environmental change and related charges including provider individual charges connected with prescribing an environmental change.

Recreation or diversional therapy.

Services and supplies, including surgical services and supplies, for treating obesity and/or weight control, even when prescribed for a medical condition.

Services and supplies related to the treatment of abuse of nicotine from tobacco and other sources, except for nicotine substitutes which require a prescription under federal law.

Services and supplies used to treat conditions to the extent that, according to generally accepted Professional Standards, such conditions are not amenable to favorable modification through medical treatment.

Therapy services to improve function to the extent that they could reasonably be expected to improve as the individual gradually resumes normal activity or could reasonably be expected to improve as a child develops.

Therapy services related to activities for the general good and welfare of patients, e.g., general exercise to promote overall fitness and flexibility; diversional, recreational, vocational therapies; therapy to improve a patient's motivation; behavior modification and training; development of social skills or coping skills; or therapy that is primarily educational in nature.

Therapy services for which the expected improvement potential would be insignificant in relation to the extent and duration of the services required to achieve such potential.

Therapy services for language training for educational, psychological or developmental speech delays.

Supportive devices for the feet; care of flat feet, fallen arches, weak feet, chronic foot strain, and toe nails; and treatment of corns, and callouses. Care of corns, callouses or toenails is covered when medically necessary because of diabetes or circulatory problems.

Vision/Eye Care Related Exclusions

Eyeglasses, contact lenses, or examinations (eye refractions) to prescribe or fit such items, except as specifically stated as covered in this booklet. The cost of the first pair of eyeglasses or contact lenses required following cataract surgery is covered.

Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and astigmatism including radial keratomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

Organ and Tissue Transplant Related Exclusions

Artificial or animal organ transplants.

Services and supplies for treatment of complications from a covered transplant procedure unless such complications are determined by the University's medical consultants to be the immediate and direct result of a covered transplant procedure.

Services and supplies rendered to a donor in conjunction with transplantation of an organ or tissue to a recipient who is not a participant in this Plan.

Services and supplies related to transplantation of any non-human organ.

Services and supplies that result from complications of a covered transplant procedure that are not the immediate and direct result of the covered transplant. (MEDICAL benefits may apply.)

Services and supplies related to the performance of transplantation of the stomach, small intestines and/or colon.

Services and supplies related to a transplant that was not approved and authorized, in writing, by the Plan in advance of the transplant.

Services and supplies that are eligible to be paid pursuant to any private or public research fund. This applies whether such funding was applied or received.

SECTION G — CLAIMS

FILING MEDICAL CLAIMS

Medical Claims

Preferred network providers will file claims for enrollees. Many other hospitals and physicians also will file an enrollee's claim; however, non-network providers may require the enrollee to pay in full and then file a claim for reimbursement. Blue Card providers in states outside Indiana will file claims with the local Blue Cross and Blue Shield plan.

For an enrollee to file a claim:

1. Ask the provider to complete the form normally used,

   or

   Obtain an itemized bill showing each service, the charge for each and the diagnosis. The bill must show the patient's name and the name of the employee.

2. Complete an IU PPO-Plus Health Care Plan Claim Form, attach the item(s) listed above and mail to:

   Anthem
   PO Box 37010
   Louisville, KY 40233-7010

3. Keep copies of all correspondence for your records. Claims will not be returned to the enrollee.

Forms may be obtained from the Anthem IU Service Center, the Human Resources office, or the University Benefits Office web page: *www.indiana.edu/~ubenefit*.

Have bills in a foreign language translated and submit both the bill and the translation.

Claims must be filed by December 31 of the year after the services were received. It is recommended that medical claims be filed promptly.

Appeal of a Medical Claim

Step 1 — Initial Request for Review

Anthem, as the Plan Administrator, reviews all claims for benefits. If Anthem denies a claim, the enrollee will be notified of the reasons for the denial. The enrollee has the right to request a review of the denial within 60 days. The enrollee has the right to review any documents relating to the claim and to submit written comments or additional documentation concerning the claim. Anthem, or its designee, will review all the information the enrollee has submitted, and may ask the enrollee to submit additional information, and will make a decision concerning the enrollee's request within sixty (60) days of having received all pertinent information. If conditions arise that prevent Anthem from reviewing the enrollee's request within sixty (60) days, it may obtain an additional sixty days extension by notifying the enrollee of the delay. After review of the enrollee's claim, Anthem will furnish the enrollee with a written explanation of its decision.

Step 2 - Request for Appeal

If the enrollee wishes to appeal Anthem's initial review decision, a written request for appeal must be submitted to Anthem within sixty (60) days after the decision on the review. Anthem will then have the previous decision and any additional information reviewed by different individual(s). Anthem will have sixty (60) days from the submission of all information to authorize payment of the disputed claim or uphold its original decision to deny the claim. Written notice of the appeal decision will be made to the enrollee. If a written request for appeal is not received within sixty days after the initial review, the enrollee forfeits the right to appeal.

Appeals may be mailed to:

Appeals Department
P.O. Box 6227
Indianapolis, IN 46206-6227
317-287-6983

FILING MENTAL HEALTH AND CHEMICAL DEPENDENCY CLAIMS

Mental health and chemical dependency claims must be submitted to IUPM in order to be considered by the Plan.

IUPM network providers will submit payment claims to IUPM for consideration. Claims for services of any other provider must be filed with IUPM by the participant at the following:

Indiana University Psychiatric Management
5610 Crawfordsville Road
Building 12, Suite 1200
Indianapolis, IN 46224

To file a claim for services, the provider should use form HCFA 1500. Other forms may be acceptable if they contain the following information:

- health care plan name and identification number
- employee's name, address, and social security number
- patient information
  - full name and date of birth
  - treatment date
  - type of service and CPT4 procedure code
  - diagnosis
  - amount charged
- treating provider's name, degree, and license number

Filing a canceled check or cash register receipt is not adequate and will be returned with a request for full information.

Appeal of a Mental Health or Chemical Dependency Claim

In the event that IUPM denies a claim, the enrollee may use a formal appeals process to retrospectively review both Clinical Appeals (pre-authorization, denial of benefits, clinical care complaints, etc.) and Claims Appeals (late payment, incorrect payment, incorrect CPT coding, etc.). Resolution of complaints on an informal basis is encouraged by discussing the problem with an IUPM Case Manager or the Medical Director.

A written appeal or complaint should be addressed to IUPM, 5610 Crawfordsville Road, Building 12, Suite 1200, Indianapolis, Indiana 46224. Written notification of the decision will be sent to the enrollee within two weeks of receiving the appropriate medical documentation.

Should further consideration be requested, a written appeal would be made to the Medical Director and the Utilization Review Panel. That appeal will be addressed, and a decision will be sent to the enrollee within two weeks of receiving all pertinent medical documentation and medical records.

A third appeal level is available by submitting a written request to IUPM within seven (7) days of the level Two denial. This appeal level will consist of a review by an independent panel, who will develop a final decision. Written notification of the decision will be sent to the enrollee within seven (7) working days after the panel renders an opinion. The decision of the independent panel will be final.

FILING CLAIMS FOR PRESCRIPTION DRUGS

If an enrollee has to pay out-of-pocket for a prescription, whether from an In-Network or Out-of-Network pharmacy, a claim can be submitted to:

Scrip Pharmacy Solutions
33 North Road
Wakefield, RI 02879
Attention: IU Account Manager

Prescription claim forms are available from the University Benefits Office web page:

www.indiana.edu/~ubenefit.