Indiana University Health Plans Select

www.iuhealthplans.org

Customer Service 866-895-5828

Health Plans

2023

A Health Maintenance Organization (High)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See FEHB Facts for details. This Plan is accredited. See Section 1.

Serving: 25 Indiana Counties

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See Section 1 for requirements.

Enrollment codes for this Plan:
FS1 High Option - Self Only
FS3 High Option - Self Plus One
FS2 High Option - Self and Family

IMPORTANT
- Rates: Back Cover
- Changes for 2023: Page 14
- Summary of Benefits: Page 84

"Special notice - This plan is being offered for the first time under the Federal Employees Health Benefits Program during the 2023 Open Season."

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-909

Important Notice from Indiana University Health Plans, Inc. About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Indiana University Health Plans' prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov or call the SSA at 800-772-1213 (TTY: 800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE (800-633-4227), (TTY: 877-486-2048)

Table of Contents

Introduction

This brochure describes the benefits of IU Health Plans Select under contract (CS 2967) between Indiana University Health Plans, Inc. and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 866-895-5828 or through our website: www.iuhealthplans.org. The address for the IU Health Plans administrative office is:

Indiana University Health Plans, Inc.
an Indiana domestic health maintenance organization
950 North Meridian Street, Suite 400
Indianapolis, Indiana 46240

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2023, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member; "we" means Indiana University Health Plans, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud — Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except to your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 317-962-8873 and explain the situation.
- If we do not resolve the issue:

CALL- THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to

www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The Indiana University Health Select Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at: Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Attention: Assistant Director, FEIO, 1900 E Street NW, Suite 3400-S, Washington, DC 20415-3610.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. **Keep and bring a list of all the medications you take.**

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medication and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider’s portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital or clinic is best for your health needs.**

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use Indiana University Health Plans, Inc. preferred providers. This policy helps to protect you from having to pay for the cost of treating these conditions, and it encourages hospitals to improve the quality of care they provide.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard (MVS)**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Types of coverage available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to add a family member when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a family member if you currently have a Self Only plan.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member in another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren

Coverage: Natural children, adopted children and stepchildren are covered until their 26th birthday.

Foster children

Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support

Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children

Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance

Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2023 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2022 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or assistance or Temporary Continuation of Coverage (TCC) or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at: www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

· Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);

· You decided not to receive coverage under TCC or the spouse equity law; or

· You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert**.** You must contact us in writing within 31 days after you receive this notice**.** However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 866-895-5828 or visit our website at www.iuhealthplans.org.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory or visit our website at www.iuhealthplans.org.

OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Indiana University Health Plans, Inc. holds the following accreditations: National Committee for Quality Assurance. To learn more about this plan's accreditation(s), please visit the following website:

- National Committee for Quality Assurance (www.ncqa.org)

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Option

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. Some services require prior authorization, See section for prior authorization, "You need prior plan approval for certain services."

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

This is a direct contract Plan, which means that participating providers are neither agents nor employees of the Plan; rather, they are independent doctors and providers who practice in their own offices or facilities. The Plan arranges with licensed providers and hospitals to provide medical services for both the prevention of disease and the treatment of illness and injury for benefits covered under the Plan.

Preventative Care Services

Preventative Care Services are generally covered with no cost sharing and are not subject to copayments, deductibles, or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for other than preventative care services.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $6,000 for Self Only enrollment, and $12,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Indiana University Health Plans has been in existence since 2005
- Indiana University Health Plans is a for-profit organization

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, www.iuhealthplans.org. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 866-895-5828 or write to IU Health Plans, 950 N. Meridian St., Suite 400, Indianapolis, IN 46204. You may also visit our website at www.iuhealthplans.org.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.iuhealthplans.org to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live or work in our service area. This is where our providers practice. Our service area is made up of twenty-five counties in the state of Indiana: Blackford, Boone, Brown, Carroll, Clinton, Delaware, Fountain, Grant, Hamilton, Hendricks, Jay, Johnson, Lawrence, Marion, Monroe, Montgomery, Morgan, Orange, Owen, Putnam, Randolph, Shelby, Tippecanoe, Tipton, and White.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. We Are A New Plan

This Plan is new to the FEHB program. We are being offered for the first time during the 2023 Open Season.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 866-895-5828 or write to us at 950 N Meridian St, Suite 400 Indianapolis, IN 46204. You may also request replacement cards through our website: www.iuhealthplans.org.

Where you get covered care

You get covered care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, if you use our Open Access program you can receive covered services from a participating network specialist without a required referral from your primary care physician or by another participating provider in the network.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. The provider directory for this plan can be found at www.iuhealthplans.org. Providers can be located by selecting the **"Employer Plan - IU Health Select Network" product option.**

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached 866-895-5828 for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website at www.iuhealthplans.org.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a general practitioner, family practitioner, internist or pediatrician. Your primary care physician will provide or coordinate most of your health care.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us or visit our website. We will help you select a new one.

- **Specialty care**

Your primary care physician may refer you to a specialist for needed care or you may go directly to a specialist without a referral. However, some services require prior authorization. A prior authorization list can be found at www.iuhealthplans.org.

Here are some other things you should know about specialty care:

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist.
- If you have a chronic and disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause;

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Program plan; or

  - reduce out service area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 866-895-5828. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

You must get prior approval for certain services. Failure to do so will result in services not being covered.

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

For a complete list of services that require a prior authorization refer to: www.iuhealthplans.org.

Your provider can fax completed prior authorization forms to Population Health Medical Management at 317-962-6219 or call 317-962-2378 if your provider have questions about prior authorization and referrals. Medical Management is open Monday through Friday, 8:30 a.m. - 4:30 p.m. For urgent requests on weekends/holidays call 317-962-2378.

How to request precertification for an admission or get prior authorization for Other services

First, your physician or hospital must call us at 317-962-2378 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you verbally within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours (1) of the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 866-895-5828. You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 866-895-5828. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within 48 hours following the day of the emergency admission or as soon as possible within a reasonable period of time even if you have been discharged from the hospital.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than a total of 48 hours for vaginal delivery or a total of 96 hours for cesarean section, then your physician or the hospital must contact us to pre-certify additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 844-432-0704.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

  1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
  2. Ask you or your provider for more information.

     You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

     If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician, you pay a copayment of $25 per office visit or a copayment of $35 per office visit when you see a participating specialist.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Example: With IU Health Plans Select, you will need to meet the deductible of $250 for Self Only enrollment or $500 for Self Plus One or Self and Family enrollment. Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: In our Plan, you pay 10% of our allowance for durable medical equipment.
Differences between our Plan allowance and the bill	You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your (copayments and coinsurance) total $6,000 for Self Only enrollment or $12,000 for Self Plus One enrollment or Self and Family enrollment for the High Option in any calendar year, you do not have to pay any more for covered services. Once an individual meets the Self Only out-of-pocket maximum under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical expenses at 100%. The remaining balance of the Self Plus One and Self and Family out-of-pocket maximum can be satisfied by one or more family members. Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the Plan's calculation of your out-of-pocket maximum is reflected accurately.
Carryover	If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating health care provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities, but you receive some care from nonparticipating providers.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from unexpected bills.

In addition, State of Indiana does not have an independent law and abides by NSA federal law and the requirements described under Code section 9816, ERISA section 716, and PHS Act section 2799A-1.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to iuhealthplans.org or contact the health plan at 866-895-5828.

The Federal Flexible Spending Account Program - *FSAFEDS*

- **Healthcare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you, your tax dependents, and your adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High Option Benefits

See Summary of Benefits for a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High Option Benefits Overview

The benefit package for the High Option is described in Section 5, which is divided into subsections 5(a) through 5(h). Make sure that you review the benefits that are available under the option in which you are enrolled.

Please read Important things you should keep in mind at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about benefits, contact customer service at 866-895-5828 or on our website at www.iuhealthplans.org. Each option offers unique features. Members do not need to have referrals to see specialists.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- If you live or work in an IU Health Plans Select area, you should select a PCP by calling Member Services at 866-895-5828.
- If you live or work in an IU Health Plans Select area, you do not have to obtain a referral from your PCP to see a network specialist.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office	$25 per primary care physician (PCP) visit $35 per specialist visit
• During a hospital stay • Inpatient Skilled Nursing Facility Services (limited to a maximum of 90 days per Enrollee Per Year)	$250 Copayment. Waived if admitted. 10% Coinsurance after Deductible
• In an urgent care center	$30 per visit
• At home	10% Coinsurance after deductible
Telehealth services	**High Option**
• Telehealth Services	$20 Copayment per visit
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and electroencephalogram (EEG)	10% Coinsurance after deductible

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**High Option**
• Sleep Studies	10% Coinsurance after deductible
Diagnostic tests limited to: • X-ray and other radiology services, including mammograms for any person diagnosed with breast disease. • Magnetic Resonance Angiography (MRA). • Magnetic Resonance Imaging (MRI). • CAT scans. • Laboratory and pathology services. • Cardiographic, encephalographic, and radioisotope tests. • Nuclear cardiology imaging studies. • Ultrasound services. • Allergy tests. • Electrocardiograms (EKG). • Electromyograms (EMG) except that surface EMGs are not Covered Services. • Echocardiograms. • Bone density studies • Positron emission tomography (PET scanning). • Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure. • Echographies • Doppler studies. • Brainstem evoked potentials (BAER) • Somatosensory evoked potentials (SSEP) • Visual evoked potentials (VEP). • Nerve conduction studies. • Muscle testing. • Electrocorticograms. Note: The services need precertification. See Section 3 "Services requiring our prior approval". *Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition.	10% Coinsurance after Deductible
• Genetic Counseling and Evaluation for BRCA Testing • Genetic Testing for BRCA-Related Cancer* *Note: Requires precertification. See Section 3 "Services requiring our prior approval".	Nothing

Benefit Description	You pay
Preventive care, adult	**High Option**
• Routine physicals - one (1) exam every calendar year The following preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/ DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women, please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing
Routine mammogram - covered • One (1) every calendar year; or when medically necessary	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing
Not covered: • *Physical exams, immunizations, and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**High Option**
• Well-child visits, examinations, and immunizations other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
• Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html	Nothing
• You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal Care • Screening for gestational diabetes • Delivery • Postnatal care	No copay for routine prenatal care or postpartum care visit 10% Coinsurance after Deductible
Breastfeeding support, supplies and counseling for each birth. Note: Here are some things to keep in mind: You do not need to precertify your vaginal delivery; see page 18 for other circumstances, such as extended stays for you or your baby.	Nothing
• You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).	.

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	.
Not covered: If Maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.	*All charges*
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal ligation Note: We cover oral contraceptives under the prescription drug benefit.	Nothing
• Voluntary sterilization (See Surgical procedures Section 5 (b))	10% Coinsurance after Deductible
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*
Infertility services	**High Option**
Infertility is a disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (6 months for women age 35 or older). Diagnosis and treatment of infertility, such as: • Testing for diagnosis and surgical treatment of the underlying medical cause of infertility. • Fertility preservation procedures (retrieval of and freezing of eggs or sperm) for members facing the possibility of infertility caused by chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or ovary or testicle removal for treatment of disease.* ** • *Any assisted reproductive technology (ART) procedure or services related to such procedures, including but not limited to in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection (ICSI) or* - *Artificial insemination (AI) and monitoring of ovulation:* • *Intravaginal insemination (IVI)* • *Intracervical insemination (ICI)* • *Intrauterine insemination (IUI)* - *Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries*	10% Coinsurance after Deductible, up to a combined annual limit of $20,000 for medical and prescription drugs.

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
- *Any charges associated with care required to obtain artificial insemination or ART services (e.g. office, hospital, ultrasounds, laboratory tests, etc); and any charges associated with obtaining sperm for any artificial insemination or ART procedures except as stated above* - *The purchase of donor sperm when necessary for conception; the purchase of donor eggs when necessary for conception; and, any charges associated with care of the donor required for donor egg retrievals or transfers* - *Injectable fertility drugs including but not limited to menotropins, hCG, GnRH agonists, and IVIG.* - *Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services.* - *Services and supplies related to the above mentioned services, including sperm processing* - *Infertility treatments such as in vitro fertilization that might be needed after the necessary medical intervention* *Note: We cover Injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.* * Subject to medical necessity ** Note: Requires Precertification. See Section 3 "Services requiring our prior approval". You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us.	10% Coinsurance after Deductible, up to a combined annual limit of $20,000 for medical and prescription drugs.
Not covered: • *All charges associated with a gestational carrier program for the covered person or gestational carrier* • *Reversal of sterilization surgery* • *Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal* • *Elective fertility preservation, such as egg freezing sought due to natural aging* • *Cost of home ovulation predictor kits or home pregnancy kits* • *Drugs related to the treatment of non-covered benefits* • *Storage costs*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	10% Coinsurance after Deductible
Allergy serum	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*

Benefit Description	You pay
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants in Section 5(b). • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy in a doctor's office or facility (For IV infusion and antibiotic treatment at home, see Home Health Services.) • Growth hormone therapy (GHT) Note: Treatment therapies may require prior authorization. Please call 317-962-2378 or 866-492-5878 to determine medical necessity and prior authorization. Note: Growth hormone therapy is covered under the prescription drug benefit. We will only cover GHT when we preauthorize the treatment. Call 317-962-2378 or 866-492-5878 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it is authorized by IU Health Plans. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	10% Coinsurance after Deductible
Non-Preventive Medical Nutritional Therapy	Nothing
Not covered: • *Food additives are not covered in all cases.* • *Grocery items and over-the-counter items are non-covered in all cases.* • *Nutritional supplements must be considered a Medical Food in order to be covered.* • *Medical Food Not Medically Necessary and not covered.*	*All charges*
Physical and occupational therapies	**High Option**
20 visits per person, per calendar year for physical or occupational therapy for the services of each of the following: • Qualified Physical therapists • Occupational therapists Note: We only cover therapy when a physician: • Orders the care; • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed.	10% Coinsurance after Deductible
Not covered:	*All charges*

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	**High Option**
• Repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients). • *Range of motion and passive exercises that are not related to restoration of a specific loss of function but are for maintaining a range of motion in paralyzed extremities* • *General exercise programs, diathermy, ultrasound, and heat treatments for pulmonary conditions* • Diapulse • Work hardening • Maintenance therapy to delay or minimize muscular deterioration in patients suffering from chronic disease or illness	*All charges*
Pulmonary and cardiac rehabilitation	**High Option**
• 20 visits per member per calendar year of pulmonary rehabilitation to treat functional pulmonary disability • 36 visits per member per calendar year of Cardiac rehabilitation	10% Coinsurance after Deductible
Not Covered: Long-term rehabilitative therapy	*All charges*
Habilitative therapy	**High Option**
• 20 visits per person per calendar year	10% Coinsurance after Deductible.
Speech therapy	**High Option**
• 20 visits per person, per calendar year	10% Coinsurance after Deductible
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	10% Coinsurance after Deductible
Not covered: • *Hearing aids or examinations to prescribe or fit the hearing aids* • *All other hearing testing not medically necessary* • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• Treatment of eye diseases and injury	10% Coinsurance after Deductible
Pediatric Vision Services - covered services only for enrollee until the last day of the month in which they obtain the age of 19. • Pediatric eye exam • eyeglass lenses • frames • contact lenses • low vision benefits	10% Coinsurance after Deductible
Not covered: Adult vision services	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	**High Option**
• Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses • Medical and/or surgical treatment of the eye, eyes or supporting structures • An eye or vision examination, or any corrective eyewear required by your Employer as a condition of employment, safety eyewear • Plan (non-prescription) lenses and/or contact lenses • Non-prescription sunglasses • Two pair of glasses in lieu of bifocals • *Fitting of contact lenses* • *Vision therapy, including eye patches and eye exercises, e.g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays* • *Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	10% Coinsurance after Deductible
Not covered: • *Routine foot care (including the cutting or removal of corns and calluses), nail trimming, cutting, or debriding, hygienic and preventive maintenance foot care, including but not limited to cleaning and soaking the feet, applying skin creams in order to maintain skin tone, and other services that are performed when there is not a localized illness, injury or symptom involving the foot* • *Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses* • *Foot orthotics* • *Podiatric shoe inserts*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Orthopedic devices such as braces and prosthetic devices such as artificial limbs and eyes. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), penile implants, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • cochlear implant • Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.)	10% Coinsurance after Deductible

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
Note: Certain devices require precertification by you or your physician. Please see Section 3 for a list of services that require precertification.	10% Coinsurance after Deductible
• Hair prosthesis prescribed by a physician for hair loss resulting from radiation therapy, chemotherapy or certain other injuries, diseases, or treatment of a disease.	10% Coinsurance after Deductible. Coverage includes the first one following cancer treatment resulting in hair loss, not to exceed one per calendar year.
Not covered: • *Dentures, replacing teeth or structures directly supporting teeth unless related to an accident or approved facial reconstruction* • *Dental appliances* • *Such non-rigid appliances as elastic stockings, garter belts, arch supports, and corsets* • *Artificial heart implants* • *Wigs (except as described above following cancer treatment)* • *Penile prosthesis in men suffering impotency resulting from disease or injury* • *Hearing aids, testing, fitting and the examination for them* • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Contact the plan for a complete list of covered DME. Some covered items include: • Oxygen • Dialysis equipment • Hospital beds (Clinitron and electric beds must be preauthorized) • Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Insulin pumps and related supplies such as needles and catheters • Nutritional formulas for the treatment of inherited metabolic diseases, including histidinemia, homocystinuria, maple syrup urine disease, phenylketonuria, and tyrosinemia, as well as specialized infant formulas (e.g., Alimentum, Elecare, Neocate, and Nutramigen) in the presence of such conditions as severe food protein allergies, when administered under the direction of a Plan doctor. Note: You must get your DME from a participating DME provider. Some DME may require precertification by you or your physician.	10% Coinsurance after Deductible
Not covered: • *Elastic stockings and support hose*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• *Bathroom equipment such as bathtub seats, benches, rails and lifts* • *Home modifications such as stair glides, elevators and wheelchair ramps* • *Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities*	*All charges*
Home health services	**High Option**
• Home health services ordered by a Plan Physician and provided by nurses and home health aides through a participating home health care agency. Home health services include skilled nursing services provided by a licensed nursing professional; services provided by a physical therapist, occupational therapist, or speech therapist; and services of a home health aide when provided in support of the skilled home health services. Home health services are limited to a maximum of 100 visits per enrolee per year. • Private Nursing Visits are limited to a maximum of 82 visits per enrollee per year and 164 visits per enrollee per lifetime	10% Coinsurance after Deductible
Not covered: • Food, that is not a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a physician • housing, homemaker services and home delivered meals. • Physician charges except for Telehealth and Hospital at Home • Home hemodialysis services • Helpful environmental materials (handrails, ramps, telephones, air conditioners, and similar services, appliances, and devices). • Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider • Services provided by volunteer ambulance associations for which patient is not obligated to pay. • Visiting teachers, vocational guidance, and other counselor • Services related to outside, occupational, and social activities	*All charges*
Chiropractic	**High Option**
Chiropractic services up to 12 visits per member per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electric muscle stimulation, vibratory therapy and cold pack application	10% Coinsurance after Deductible
Not covered: • *Any services not listed above* • *Manipulation Therapy services rendered in the home as part of Home Care Services are not covered*	*All charges*

Benefit Description	You pay
Alternative medicine treatments	**High Option**
Acupuncture	Not covered
Not covered: Other alternative medical treatments including but not limited to: • *Acupuncture other than stated above* • *Holistic medicine* • *Homeopathy* • *Hypnosis* • *Aroma therapy* • *massage and massage therapy* • *reiki therapy* • *herbal* • *vitamin or dietary products or therapies* • *naturopathy* • *thermography* • *orthomolecular therapy* • *contact reflex analysis* • *bioenergy synchronization technique*	*All charges*
Educational classes and programs	**High Option**
Indiana University Health, Inc. offers disease management for multiple conditions. Included are programs for: • Asthma • Cerebrovascular disease • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Coronary artery disease • Cystic Fibrosis • Depression • Diabetes • Adult and Child obesity screening programs and treatment interventions • Hepatitis • Inflammatory bowel disease • Kidney failure • Low back pain • Sickle Cell disease To request more information on our disease management programs, call 866-895-5828.	Nothing
Coverage is provided for: • Tobacco cessation Programs including individual/group/phone counseling, and for over-the-counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence.	Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat nicotine dependence.

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
Note: OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat nicotine dependence.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (See *Reconstructive surgery*) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization for men (e.g., vasectomy) • Treatment of burns • Skin grafting and tissue implants • Gender affirming surgery**	10% Coinsurance after Deductible

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
** Note: Requires Precertification. See Section 3 "Services requiring our prior approval". You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 866-492-5878.	10% Coinsurance after Deductible
Voluntary sterilization for women (e.g., tubal ligation)	Nothing
Not covered: • *Bariatric surgery* • *Reversal of voluntary surgically-induced sterilization* • *Surgery primarily for cosmetic purposes* • *Radial keratotomy and laser surgery, including related procedures designed to surgically correct refractive errors* • *Routine treatment of conditions of the foot; (see Foot care)* • *Gender reassignment services that are not considered medically necessary*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital and developmental anomalies are cleft lip, cleft palate, webbed fingers and webbed toes. All surgical requests must be preauthorized. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedema - Breast prostheses and surgical bras and replacements (*See Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Gender affirming surgery (including, but not limited to)**	10% Coinsurance after Deductible

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
- Surgical removal of breasts for female-to-male patients - Breast augmentation (implants/lipofilling) in male-to-female patients - Surgical removal of uterus and ovaries in female-to-male and and testes in male-to-female - Reconstruction of external genitalia** ** Note: Requires Precertification. See Section 3 "Services requiring our prior approval". You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 866-492-5878.	10% Coinsurance after Deductible
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, that are medical in nature, such as: • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); • Excision of tumors and cysts; and • Removal of bony impacted wisdom teeth	10% Coinsurance after Deductible
Not covered: • *Dental implants* • *Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis] • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver	10% Coinsurance after Deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	10% Coinsurance after Deductible
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome	
• Autologous Transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	
• **National Transplant Program (NTP) -** Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your primary care doctor and plan specialist physician and approved by our medical director in advance of the surgery. The transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program. *Note: Transplants must be performed at hospitals designated as Institutes of Excellence (IOE). Hospitals in our network, but not designated as an IOE hospital will not be covered.	Refer to Note

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four allogenic bone marrow/ stem cell transplant donors in addition to the testing of family members.	Refer to Note
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note**:** For sedation or anesthesia relating to dental services performed in a dental office, see Section 5(g), Dental benefits. Note: When the anesthesiologist is the primary giver of services, such as for pain management, the specialist copay applies.	10% Coinsurance after Deductible

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, Immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	$250 Copayment

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
Not covered: • *Non-covered facilities, such as nursing homes, schools* • *Custodial care, rest cures, domiciliary or convalescent cares* • *Personal comfort items, such as phone and television* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Radiologic procedures, diagnostic laboratory tests, and X-rays when associated with a medical procedure being done the same day • Pathology Services • Administration of blood, blood plasma, and other biologicals • Blood products, derivatives and components, artificial blood products and biological serum • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), penile implants, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal. Note: Certain devices require precertification by you or your physician. Please see Section 3 for a list of services that require precertification. Note: Preventive care services are not subject to copays listed.	$100 Copayment
Not covered: Whole blood and concentrated red blood cells not replaced by the member.	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Inpatient Skilled Nursing Facility Services • limited to a maximum of 90 days per member per year	10% Coinsurance after Deductible
Not covered: Custodial care	*All charges*

Benefit Description	You pay
Hospice care	**High Option**
Hospice care may be provided in the home or at a hospice facility where medical, social, and psychological services are given to help treat patients with a terminal illness. Hospice services include routine home care, continuous home care, Inpatient hospice, and Inpatient respite. To be eligible for hospice Benefits, the patient must have a life expectancy of six months or less, as certified by the attending physician and hospice medical director. Covered Services will continue if the Enrollee lives longer than six months, provided the hospice medical director or other hospice physician recertifies that the Enrollee is terminally ill.	10% Coinsurance after Deductible
Not covered: Separately billed services provided by volunteers and housekeeping services	All charges
Ambulance	**High Option**
Ambulance Services are transportation by a vehicle (including ground, water, and Air Ambulance transportation) designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals: • From your home, scene of an accident or medical Emergency to a Hospital • Between Hospitals • Between a Hospital and Skilled Nursing Facility; or • From a Hospital or Skilled Nursing Facility to your home, if Medically Necessary • From a Health Care Facility to a Hospital • Between the Enrollee's residence and a Health Care Facility • Between a site of transfer and a Hospital	10% Coinsurance after Deductible
Not covered: • *A trip to a morgue or funeral home* • *Any Ambulance usage for the convenience of an enrollee, family, or provider* • *Ambulance transportation for member convenience or reasons that are not medically necessary* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works.
- We define observation as monitoring patients following medical or surgical treatments to determine if you need more care, need admission or can be discharged. Observation care can be billed as Emergency Room, Outpatient, or Inpatient depending on where services are rendered, benefited accordingly and how it is billed to us within the scope of the facilities contract. Hospital observation cost share is determined as anything greater than 23 hours, and IU Health Plans' policy is to allow up to 48 hours of hospital observation without preauthorization. After 48 hours, facilities must determine if they are going to discharge or admit the patient from observation and if admitting they will be responsible to preauthorize. Once admitted, inpatient hospital member cost sharing will apply

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our Service Area:

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Whether you are in or out of an IU Health Plans service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

- Call the local emergency hotline (e.g., 911) or go to the nearest emergency facility. For non-emergency services, care may be obtained from a retail clinic, a walk-in clinic, an urgent care center or by calling Teladoc. If a delay would not be detrimental to your health, call your primary care physician. Notify your primary care physician as soon as possible after receiving treatment.
- After assessing and stabilizing your condition, the emergency facility should contact your primary care physician so they can assist the treating physician by supplying information about your medical history.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify IU Health Plans as soon as possible.

Emergencies outside our Service Area:

If you are traveling outside your IU Health Plans service area or if you are a student who is away at school, you are covered for emergency and urgently needed care. For non-emergency services, care may be obtained from a walk-in clinic, an urgent care center or by calling Teladoc. Urgent care may be obtained from a private practice physician, a walk-in clinic, or an urgent care center. Certain conditions, such as severe vomiting, earaches, or high fever are considered "urgent care" outside your IU Health Plans service area and are covered in any of the above settings.

If, after reviewing information submitted to us by the provider that supplied care, the nature of the urgent or emergency problem does not qualify for coverage, it may be necessary to provide us with additional information. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by phone.

Follow-up Care after Emergencies

All follow-up care should be coordinated by your PCP or network specialist. Follow-up care with non-participating providers is only covered with a referral from your primary care physician and pre-approval from IU Heath Plans. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency or urgent care at a doctor's office	$25 per PCP visit $35 per specialist visit
• Emergency or urgent care at an urgent care center	$30 per visit
• Emergency Outpatient Care at a Hospital	$250 Copayment per visit Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**High Option**
• Emergency or urgent care at a doctor's office	$25 per primary care visit $35 per specialist visit
• Emergency or urgent care at an urgent care center	$30 per visit
• Emergency Outpatient Care at a Hospital	$250 per visit Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges*
Telehealth services	**High Option**
IU Health Virtual Visits app- iuhealth.org/virtualvisits	$20 Copayment per visit
Ambulance	**High Option**
Ambulance Services are transportation by a vehicle (including ground, water, and Air Ambulance transportation) designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals: • From your home, scene of an accident or medical Emergency to a Hospital • Between Hospitals	10% Coinsurance after Deductible

Ambulance - continued on next page

Benefit Description	You pay
Ambulance (cont.)	**High Option**
• Between a Hospital and Skilled Nursing Facility; or • From a Hospital or Skilled Nursing Facility to your home, if Medically Necessary • From a Health Care Facility to a Hospital • Between the Enrollee's residence and a Health Care Facility • Between a site of transfer and a Hospital	10% Coinsurance after Deductible
Not covered: • *A trip to a morgue or funeral home* • *Any Ambulance usage for the convenience of an enrollee, family, or provider* • *Ambulance transportation for member convenience or reasons that are not medically necessary* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR CERTAIN SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. **Please see Section 3 of this brochure for a list of services that require preauthorization.**
- We will provide medical review criteria for denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Outpatient Services $25 per visit Inpatient Services $250 per visit

Benefit Description	You pay
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$25 per outpatient visit $250 per inpatient visit
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility including an overnight residential treatment facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$250 per visit
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$25 per outpatient visit
Not covered	**High Option**
• *Custodial or domiciliary care* • *Supervised living or halfway houses* • *Services or care provided or billed by residential treatment center, school, or halfway house* • *Custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward-bound programs, even if psychotherapy is included* • *Services related to Medical Non-Compliance of care if the Enrollee ends treatment for substance abuse against the medical advice of the Provider*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Certain drugs require your doctor to get prior authorization from the Plan before they can be covered under the Plan. Upon approval by the Plan, the prescription is covered for the current calendar year or a specified time period, whichever is less.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You may fill non-emergency prescriptions at a participating Plan retail pharmacy or by mail order for up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one (1) copay, and for a 31-day up to a 90-day supply of medication for two (2) copays. In no event will the copay exceed the cost of the prescription drug. Please call Member Services at 844-432-0704 for more details on how to use the mail order program. **Mail order is not available for drugs and medications ordered through a network specialty pharmacy. Prescriptions ordered through a network specialty pharmacy are only filled for up to a 30-day supply due to the nature of these prescriptions.** In an emergency or urgent care situation, you may fill your covered prescription at any retail pharmacy. For retail pharmacy transactions, you must present your IU Health Plans Member ID card at the point of sale for coverage. If you obtain an emergency prescription at a pharmacy that does not participate with the plan, you will need to pay the pharmacy the full price of the prescription and submit a claim for reimbursement subject to the terms and conditions of the plan.
- **IU Health Pharmacies.** IU Health has pharmacies located in IU Health hospitals and some facilities. Enrollees receive a discount on the copayment if the IU Health pharmacy is utilized to fill a prescription. If there is not a location easily accessible, prescriptions can be billed utilizing the CVS Caremark network of pharmacies.
- **We use a formulary.** IU Health Plans prescription drug benefit is administered by a pharmacy benefit manager, CVS Caremark. CVS Caremark works with IU Health Plans to provide a pharmacy provider network and to process pharmacy claims based on the health plan's covered prescription drug list, also called a formulary. Information about the IU Health Plans Formulary and list of participating pharmacies can be found at iuhealthplans.org or by calling 844-432-0704.
- **Drugs not on the formulary.** Formularies are developed and reviewed by the CVS Caremark Pharmacy and Therapeutics Committee, comprised of physicians, pharmacists and other clinicians that review drugs for inclusion in the formulary. They consider the drug's effectiveness and safety in their evaluation. While most of the drugs on the non-formulary list are brand drugs, some generic drugs also may be on the non-formulary list. For example, this may happen when brand medications lose their patent and the FDA has granted a period of exclusivity to specific generic manufacturers. When this occurs, the price of the generic drug may not decrease as you might think most generic drugs do. This period of exclusivity usually ranges between 3-6 months. Once this time period expires, competition from other generic manufacturers will generally occur and this helps lower the price of the drug and this may lead the Plan to re-evaluate the generic for possible inclusion on the formulary. Non-Formulary medications may be covered if the formulary medications do not work for you. If you require a Non-Formulary medication, your doctor may request coverage for the Tier 4 or Tier 5 copayment by making a request for an exception. **Remember, a generic equivalent will be dispensed, if available, unless your physician specifically requires a brand name and writes "Dispense as Written" (DAW) on the prescription, so discuss this with your doctor.**

- **Choose generics.** The Plan requires the use of generics if a generic drug is available. If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/ coinsurance* unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained from the Plan. Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approved by the FDA. By using generic drugs, you will see cost savings, without jeopardizing clinical outcome or compromising quality. *The differential/penalty will not apply to Plan accumulators (example: out-of-pocket maximum).
- **Prior Authorization.** Your pharmacy benefits plan includes prior authorization. Prior authorization helps encourage the appropriate and cost- effective use of certain drugs. These drugs must be pre-approved by our Pharmacy Utilization Management Unit before they will be covered. Only your physician or pharmacist can request prior authorization for a drug. Step-therapy is another type of prior authorization. Certain medications will be excluded from coverage unless you try one or more "step" drug(s) first, or unless a medical exception is obtained. The drugs requiring prior authorization or step-therapy are subject to change. Visit our website at iuhealth.org for the most current information regarding the prior authorization and step-therapy lists. Ask your physician if the drugs being prescribed for you require prior authorization or step-therapy.
- **These are the dispensing limitations.** Prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy or by mail order may be dispensed for up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay, and a 31-day up to a 90-day supply of medication for two copays. In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available, unless your physician specifically requires a brand name.

  In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact IU Health Plans. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member's current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable copayment for the additional prescription.
- The Plan allows coverage of a medication refill when at least 80% of the previous prescription, according to the physician's prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a prescription refill to be covered 24 days after the last filling, thereby allowing a member to have an additional supply of their medication, in case of emergency.

Here are some things to keep in mind about our prescription drug program:

- A generic equivalent may be dispensed if it is available, and where allowed by law.
- **Specialty drugs.** Specialty drugs are medications that treat complex, chronic diseases which includes select oral, injectable and infused medications. The first fill including all subsequent refills of these medications must be obtained through a network specialty pharmacy.

  Certain Specialty Formulary medications identified on the Specialty Drug List next to the drug name maybe covered under the medical or pharmacy section of this brochure depending on how and where the medication is administered. If the provider supplies and administers the medication during an office visit, you will pay the applicable PCP or specialist office visit copay. If you obtain the prescribed medications directly from a network specialty pharmacy, you will pay the applicable copay as outlined in Section 5(f) of this brochure.

  Often these drugs require special handling, storage and shipping. For a detailed listing of specialty medications visit Specialty Drugs - CVS Specialty or contact us at 844-432-0704 for a copy. Note that the medications and categories covered are subject to change.
- To request a printed copy of the 2023 Pharmacy Drug (Formulary) Guide, call IU Health Plans at 866-895-5828. The information in the 2023 Pharmacy Drug (Formulary) Guide is subject to change. As brand name drugs lose their patents and new generics become available on the market, the brand name drug may be removed from the formulary. Under your benefit plan, this will result in a savings to you, as you pay a lower prescription copayment for generic formulary drugs. Please visit our website www.iuhealthplans.org for current 2023 Pharmacy Drug (Formulary) Guide information.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a licensed physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Drugs approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as *Not covered* • Diabetic supplies limited to - Lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips - Insulin - Disposable needles and syringes needed to inject covered prescribed medications • Prenatal vitamins (as covered under the plan's formulary) • Anti Obesity drugs • Drugs to treat gender dysphoria - Testosterone therapy - Estrogen/progesterone therapy - Luteinizing Hormone-Releasing Hormone (LHRH) Agonists - Anti-Androgens Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	• IU Health Retail Pharmacy Tier 1 (Preferred Generics) - $2 copay Tier 2 (Generics) - $5 copay Tier 3 (Preferred Brands) - 25% Coinsurance after deductible Tier 4 (Non-Preferred Brands and Generics) - 45% Coinsurance after deductible Tier 5 (Specialty) - 45% up to $350 maximum per Specialty drug. • CVS Caremark Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: Tier 1 (Preferred Generics) - $3 copay Tier 2 (Generics) - $6 copay Tier 3 (Preferred Brands) - 30% Coinsurance after deductible Tier 4 (Non-Preferred Brands and Generics) - 50% Coinsurance after deductible Tier 5 (Specialty) - 50% up to $350 maximum per Specialty drug. • Retail Pharmacy or Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: Tier 1 (Preferred Generics) - $6 copay Tier 2 (Generics) - $12 copay Tier 3 (Preferred Brands) - 30% Coinsurance after deductible Tier 4 (Non-Preferred Brands and Generics) - 50% Coinsurance after deductible Specialty drugs limited to a 30 day supply
Contraceptive drugs and devices as listed in the ACA/HRSA site. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). • Oral contraceptives on our formulary list • Emergency contraception, including over-the-counter (OTC) when filled with a prescription • Injectable contraceptives on our formulary list - four (4) vials per calendar year	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Diaphragms - one (1) per calendar year • Condoms • Intra Uterine Device • Patch contraception on our formulary list Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Members can obtain non-preferred contraceptives with zero cost-sharing through the prior authorization exception process. An exception is approved when the prescribing provider recommends a non-preferred contraceptive based on the determination of medical necessity with respect to that individual. • Over-the-counter (OTC) contraceptives are covered at no cost if prescribed by a provider and purchased at a network pharmacy. OTC contraceptives may be processed with a valid prescription at a network pharmacy or submitted as direct member reimbursement via the CVS paper claims process and mailed directly to: CVS Caremark, P.O. Box 52136, Phoenix, Arizona 85072-2136.	Nothing
• Brand name contraceptive drugs (with generic alternatives) • Brand name injectable contraceptive drugs such as Depo Provera (with generic alternatives) - four (4) vials per calendar year • Brand emergency contraception (with generic alternatives) Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	• IU Health Retail Pharmacy Tier 3 (Preferred Brands) - 25% Coinsurance after deductible Tier 4 (Non-Preferred Brands and Generics) - 45% Coinsurance after deductible Tier 5 (Specialty) - 45% up to $350 maximum per Specialty drug. • CVS Caremark Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: Tier 3 (Preferred Brands) - 30% Coinsurance after deductible Tier 4 (Non-Preferred Brands and Generics) - 50% Coinsurance after deductible Tier 5 (Specialty) - 50% up to $350 maximum per Specialty drug. • Retail Pharmacy or Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: Tier 3 (Preferred Brands) - 30% Coinsurance after deductible Tier 4 (Non-Preferred Brands and Generics) - 50% Coinsurance after deductible Specialty drugs limited to a 30 day supply

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Specialty Medications **Specialty medications must be filled through a network specialty pharmacy.** These medications are not available through the mail order benefit. Certain Specialty Formulary medications identified on the Specialty Drug List next to the drug name may be covered under the medical or pharmacy section of this brochure.	Up to a 30-day supply per prescription or refill: • IU Health Retail Pharmacy - 45% up to $350 maximum per Specialty drug. • CVS Caremark Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill - 50% up to $350 maximum per Specialty drug.
Oral Infertility Prescription Drugs Note: We cover Injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	10% Coinsurance after Deductible, up to a combined annual limit of $20,000 for medical and prescription drugs.
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug) unless required by law.* • *Drugs obtained at a non-Plan pharmacy except when related to out-of-area emergency care* • *Vitamins, unless otherwise stated (including prescription vitamins), nutritional supplements, and any food item, including infant formula, medical foods and other nutritional items, even if it is the sole source of nutrition except for nutritional formulas for the treatment of phenylketonuria branched chain ketonuria, galactosemia and homocystinuria when administered under the direction of a Plan doctor (please see Durable Medical Equipment in Section 5(a)).* • *Medical supplies such as dressings and antiseptics* • *Lost, stolen or damaged drugs* • *Drugs for cosmetic purposes* • *Drugs for sexual dysfunction* • *Drugs to enhance athletic performance* • *Prophylactic drugs including, but not limited to, anti-malarials for travel* • *Compounded bioidentical hormone replacement (BHR) therapy that includes progesterone, testosterone and/or estrogen* • *Compounded thyroid hormone therapy* • *Non-prescription medications unless specifically indicated elsewhere* *Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat nicotine dependence are covered under the Tobacco cessation program with a prescription. (See Section 5 (a)). OTC drugs will not be covered unless you have a prescription and that prescription is presented at the pharmacy and processed through our pharmacy claim system.*	*All charges*

Benefit Description	You pay
Preventive medications	**High Option**
Medications to promote better health as recommended by ACA. Drugs and supplements are covered without cost-share, which includes some over-the-counter, when prescribed by a health care professional and filled at a network pharmacy. We will cover preventive medications in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations/ guidance: • Aspirin • Folic acid supplements • Oral fluoride • Statins • Breast cancer prevention drugs • HIV PrEP • Nicotine Replacement Medications (Limits apply) • Bowel Prep Medications (Required with preventive Colonoscopy) Please refer to the IU Health Plans formulary guide for a complete list of preventive drugs including coverage details and limitations: Preventative List The plan also includes an expanded preventative list Expanded Preventative List Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/ BrowseRec/Index/browse-recommendations.	Nothing
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug) unless required by law.* • *Drugs obtained at a non-Plan pharmacy except when related to out-of-area emergency care* • *Vitamins, unless otherwise stated (including prescription vitamins), nutritional supplements, and any food item, including infant formula, medical foods and other nutritional items, even if it is the sole source of nutrition except for nutritional formulas for the treatment of phenylketonuria branched chain ketonuria, galactosemia and homocystinuria when administered under the direction of a Plan doctor (please see Durable Medical Equipment in Section 5(a)).* • *Medical supplies such as dressings and antiseptics*	All charges

Preventive medications - continued on next page

Benefit Description	You pay
Preventive medications (cont.)	**High Option**
• *Lost, stolen or damaged drugs* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prophylactic drugs including, but not limited to, anti-malarials for travel* • *Compounded bioidentical hormone replacement (BHR) therapy that includes progesterone, testosterone and/or estrogen* • *Compounded thyroid hormone therapy* • *Non-prescription medications unless specifically indicated elsewhere* *Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat nicotine dependence are covered under the Tobacco cessation program with a prescription. (See Section 5 (a)). OTC drugs will not be covered unless you have a prescription and that prescription is presented at the pharmacy and processed through our pharmacy claim system.*	All charges

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Dental benefits	You Pay
Accidental injury benefit	**High Option**
Coverage is limited to palliative treatment and those services listed on the following schedule. Note: See Oral and maxillofacial surgery, section 5(b). We have no other dental benefits.	10% Coinsurance after Deductible
Not covered: Dental treatment, regardless of origin or cause, except as specified elsewhere in the Group Contract. “Dental treatment” includes but is not limited to: (a) Preventive care; (b) diagnosis; (c) treatment of or related to the teeth; (d) jawbones (except that TMJ is a Covered Service); or (e) gums, including but not limited to the following • Extraction, including removal of impacted wisdom teeth, restoration, and replacement of teeth • Medical or surgical treatments of dental conditions • Services to improve dental clinical outcomes Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service. Dental implants Dental braces	*All charges*

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
IU Health Plans member website and customer service	The IU Health Plans Member website, our secure member self-service website, provides you with the tools and personalized information to help you manage your health. Click on website from iuhealthplans.org/memberportal to register and access a secure, personalized view of your IU Health Plans benefits. You can: • Review eligibility and year to date benefit use (including out of pocket and maximum totals) • Download an electronic ID Card or request an additional paper copy • Submit claims manually • Review claims summaries • Review the explanation of benefits • Access plan documents • Read member newsletters and our handbook The member portal also links you to important resources such as the Find a Doctor or Facility and the My IU Health patient portal.
IU Health Patient Portal	If you see an IU Health provider, you can go to our My IU Health account (myiuhealth.org) to access a variety of information related ot your health and billing records.

	1 Click on Create an Account. Enter personal information (name, date of birth, last four digits of your Social Security Number and mailing address). 2 Answer questions to verify your identity. 3 Set up security questions and answers. 4 Complete the profile by creating a username and password and submitting a valid email address. If this process does not work for any reason, ask an IU Health team member to help you register at your next appointment. For additional assistance with a My IU Health patient portal account, contact the Health Information Management (HIM) team at 317.963.1661. Hours are 8 am – 5 pm ET, Monday – Friday (excluding major holidays). A comprehensive Help Guide can be found online at myiuhealth.org/patienthome/help-guide.
Services for deaf and hearing-impaired	866-895-5828; TTY/TDD 711

The Indiana University Health Maternity Program	Throughout your pregnancy journey, you can count on our team at IU Health to provide around-the-clock care. From before conception through delivery. Our IU Health hospitals offer comprehensive services for you and your baby. We'll answer you questions and address any pregnancy or birth concerns. To view information please visit iuhealth.org/maternity
Clickotine for smoking cessation	Clickotine is a smartphone (iPhone, Android, etc.) application that provides an individualized eight-week smoking cessation program. Features include personalized messaging, medication reminders, digital diversions, optional nicotine replacement therapy (NRT) distribution and coaching via the telephone quit line. Clickotine is available at no cost to IU Health Plans members. Go to the app store on your mobile device, search for Clickotine and download. Follow the on-screen instructions and enter the code 9CEB4A. If you have questions, email support@clickotine.com.
Travel and out-of-area coverage	If you have a medical issue while away from home, please contact your doctor first. He or she will be able to offer help with routine or urgent care questions. In the event of a true emergency, IU Health Plans covers emergency care services. For assistance in finding a provider outside of Indiana, contact First Health by calling 800.226.5116 or visit myfirsthealth.com.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact the plan at 866-895-5828 or visit their website at www.iuhealth.org.

Hearing Aids – IU Health Plans provides access to TruHearing program, which saves 30-60% on hearing aids. TruHearing customers save an average of $3,400 per pair when compared to national averages. Contact TruHearing at 844-222-3378, TTY: 711. A friendly Hearing Consultant will answer any questions and help to get the process started.

Employee Assistance Program – Our clinical counselors are experts in a wide range of mental health and well-being issues. Every counselor is Indiana licensed with multiple years of experience. Employee Assistance Program addresses a variety of personal concerns, including depression, stress and anxiety management, family and couple concerns, workplace conflict management, drug and alcohol abuse, grief and loss. Call 317-962-8001 or 800-745-4838, ext. 2 or visit www.iuhealth.org/employee-assistance.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical, hospital and prescription drug benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 866-895-5828 or at our website at www.iuhealthplans.org.

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your medical, hospital and vision claims to: Indiana University Health Plans, PO Box 11196 Portland, ME 04104-7196.

Submit your pharmacy claims to: CVS Caremark, P.O. Box 52136, Phoenix, Arizona 85072-2136.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call IU Health Plans' Customer Service at the phone number found on your ID card, plan brochure or plan website: iuhealthplans.org.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing IU Health Plans, Attention: Indiana University Health Plans, 950 N Meridian Street, Suite 400, Indianapolis, IN 46204 or calling 866-895-5828.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take in account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Attention: Appeals, IU Health Plans, 950 N Meridian Street, Suite 400, Indianapolis, IN 46204; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address, if you would like to receive our decision via email. Please note that by providing your email address, you may receive our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

	b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us--if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

	You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute. Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 866-895-5828. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance x at 202 606-0737 between 8 a.m. and 5 p.m. Eastern Time. Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.iuhealthplans.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowed amount.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/ HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

· Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.

· Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.

· Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 866-895-5828 or see our website at www.iuhealthplans.org.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
High Option You pay without Medicare: $250 self only/ $500 family
High Option You pay with Medicare Part B: $250 self only/ $500 family

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
High Option You pay without Medicare: $6,000 self only/$12,000 family
High Option You pay with Medicare Part B: $6,000 self only/$12,000 family

Benefit Description: Part B Premium Reimbursement Offered
High Option You receive without Medicare: $0
High Option You receive with Medicare Part B: $0

Benefit Description: Primary Care Physician
High Option You pay without Medicare: $25 Copayment per visit
High Option You pay with Medicare Part B: $25 Copayment per visit

Benefit Description: Specialist
High Option You pay without Medicare: $35 Copayment per visit
High Option You pay with Medicare Part B: $35 Copayment per visit

Benefit Description: Inpatient Hospital
High Option You pay without Medicare: $150 Copayment per visit
High Option You pay with Medicare Part B: $150 Copayment per visit

Benefit Description: Outpatient Hospital
High Option You pay without Medicare: $100 Copayment per visit
High Option You pay with Medicare Part B: $100 Copayment per visit

Benefit Description: Incentives offered
High Option You receive without Medicare: $0
High Option You receive with Medicare Part B: $0

You can find more information about how our plan coordinates benefits with Medicare in our Benefits Guide at www.iuhealthplans.org.

Tell us about your Medicare Coverage

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓ *
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Affordable Care Act or ACA	The Patient Protection and Affordable Care Act, Public Law 111- 148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.
Allowed Amount	The amount a Participating Provider has agreed to accept as payment in full for the provision of Covered Services.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	See Section 4.
Copayment	See Section 4.
Cosmetic Services	Health Care Services primarily intended to preserve, change or improve the Enrollee's appearance or are furnished for psychiatric or psychological reasons.
Cost-sharing	See Section 4.
Covered services	Health Care Services performed, prescribed, directed or authorized by a Provider and for which the Group Contract provides Benefits. To be a Covered Service, the Health Care Service must be all of the following: • Medically Necessary. • Within the scope of the license of the Provider. • Rendered while coverage under the Group Contract is in force. • Not experimental/investigative. • Authorized in advance by us if Precertification is required under the Group Contract. • Not excluded or limited by the Group Contract.
Custodial care	Any type of care provided according to Medicare guidelines, including Nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care. Custodial care is not covered.
Deductible	See Section 4.
Designated Representative	An individual you have appointed to assist or represent you with a Grievance, Appeal, or External Review. This person may include Providers, attorneys, friends, or family members. You must identify your Designated Representative to us in writing in order to prevent disclosure of your medical information to unauthorized persons. If you would like to designate a representative, you will need to complete a Designation of Representation form. The form is available online at iuhealthplans.org or, upon your request, we will forward a form to you for completion. If we do not obtain a completed Designation of Representation form, we will proceed in our investigation of your Grievance, Appeal or External Review, however, all communication related to such review will be directed to you and we will respond to inquiries submitted by you only.

Emergency Care

With respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the Emergency department of a Hospital or a Freestanding Independent Emergency Department, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition and within the capabilities of the staff and facilities available at the Hospital or Independent Freestanding Emergency Department, and such further medical examination and treatment to stabilize the patient. The term "stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant person who is having contractions, the term "stabilize" also includes the delivery (including the placenta) if there is inadequate time to effect a safe transfer to another Hospital before delivery or a transfer may pose a threat to the health or safety of the pregnant person or the unborn Child.

Experimental or Investigational Services

We will deem any drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if we determine that one or more of the following criteria apply when the Health Care Service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply satisfies any or all of the following listed below:

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

Emergency Medical Condition or Emergency

A medical condition, including a mental health condition or substance abuse disorder. that arises suddenly and unexpectedly and manifesting itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in any of the following:

- Placing a person's health (or, with respect to a pregnant person, the health of such pregnant person or the unborn Child of the pregnant person) in serious jeopardy.
- Serious impairment to a person's bodily functions.
- Serious dysfunction of a bodily organ or part of a person.

Employer

The entity to which the Group Contract has been issued.

Enrollee

the Subscriber or any Dependent:

- Who meets all applicable eligibility requirements for coverage under the Group Contract;
- Who is enrolled as provided in the Contract; and,
- For whom the required premium payment has been received by us.

Enrollees are also referred to as "you" and "your" in this Evidence of Coverage.

Group Contract

The contract between Indiana University Health Plans, Inc. and the Employer that provides Benefits for Covered Services for Subscribers and enrolled Dependents. The Group Contract consists of the Evidence of Coverage, the Schedule of Benefits and any amendments or riders to any of these documents. The Summary of Benefits and Coverage and marketing materials are not considered a part of the Group Contract.

Health Care Services

Medical or health care services, including services for Behavioral Health, whether or not covered under the Group Contract, which include but are not limited to: medical evaluations, diagnoses, treatments, procedures, drugs, therapies, devices and supplies.

Hospital

An institution that is operated and licensed under law and is primarily engaged in providing Health Care Services on an Inpatient basis.

Inpatient

Receipt of Health Care Services as a registered bed patient in a Hospital or other Provider where room and board charge is made.

Medical Food

Medical Food is a food that is Medically Necessary and prescribed by a Provider for the treatment of an inherited metabolic disease or inherited metabolic disorders for the primary or sole source of nutrition. Medical Food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a physician.

Medically Necessary

Those Health Care Services that we determine to be all of the following:

- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the Enrollee's illness, injury or disease.
- Required for the direct care and treatment or management of the Enrollee's illness, injury or disease.
- If not provided, the Enrollee's condition would be adversely affected.
- Provided in accordance with generally accepted standards of medical practice.
- Not primarily for the convenience of the Enrollee, the Enrollee's family, the physician or another prescribing Provider.
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Enrollee's illness, injury or disease.

We will decide whether a Health Care Service is Medically Necessary. We will base our decision in part on a review of the Enrollee's medical records and will also consider reports in peer reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment, the opinion of health professionals in the generally recognized health specialty involved, the opinion of the attending physicians and other medical Providers, which have credence but do not override contrary opinions and any other relevant information brought to our attention.

The definition of Medically Necessary under the Group Contract relates only to coverage and may differ from the way a Provider engaged in the practice of medicine may use the term. The fact that a Provider has furnished, prescribed, ordered, recommended or approved the Health Care Service does not make it Medically Necessary or mean that we must provide coverage for it.

Minimum Essential Coverage (MEC)

Any of the following types of coverage.

- Government Sponsored programs (such as Medicaid, Medicare, CHIP, Veteran's health care programs, Refugee Medical Assistance and student health coverage).
- An Employer sponsored health benefit plan.

- Individual health coverage.
- State health benefits high risk pool.
- Other programs recognized by the U.S. Department of Health and Human Services as Minimum Essential Coverage.

Non-Covered Services Health Care Services that are not covered under the terms of the Group Contract.

Non-Participating Provider or Non-Participating Pharmacist/ Pharmacy A Provider that has not entered into a contractual agreement with us or is not otherwise engaged by us to provide Health Care Services to Enrollees under the Group Contract.

Outpatient Receipt of Health Care Services while not an Inpatient.

Out-of-Pocket Maximum The maximum amount Enrollees will pay for Covered Services in a Calendar Year. The Out-of-Pocket Maximum includes the Deductible, Copayments and Coinsurance Percentage. The Out-of-Pocket Maximum is shown in the Schedule of Benefits and applies as follows:

- The *"Per Enrollee"* Out-of-Pocket Maximum is the amount that must be satisfied by each Enrollee, except as provided under the *"Per Family"* Out-of-Pocket Maximum provision.
- The *"Per Family"* Out-of-Pocket Maximum is the maximum Out-of-Pocket amount that applies if the Subscriber has Family Coverage. Each Enrollee can satisfy the entire "Per Enrollee" Out-of-Pocket Maximum until the total "Per Family" Out-of-Pocket Maximum is met for the Calendar Year. The "Per Enrollee" Out-of-Pocket amounts accumulate until the "Per Family" Out-of-Pocket Maximum is satisfied. The "Per Family" Out-of-Pocket Maximum can be satisfied by any combination of Cost Sharing paid by or for the Enrollees. At no time will the combined "Per Enrollee" Out-of-Pocket Maximum amounts exceed the "Per Family" Out-of-Pocket Maximum.

Participating Provider or Participating Pharmacy/ Pharmacist A Provider that has entered into a contractual agreement or is otherwise engaged by us or another Provider that has an agreement with us to provide Health Care Services to Enrollees under the Group Contract.

Post-Service Claims Any claims that are not pre-service claims. In other words, post-service claims are those claims were treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-Service Claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Precertification or Prior Authorization A required review of a Health Care Service for a Benefit coverage determination which must be done prior to the Health Care Service start date.

Preventive care Health care services designed for prevention and early detection of illnesses in average risk people, generally including routine physical examinations, tests and immunizations.

Primary Care Physician (PCP) A Participating Provider practicing and duly licensed as a physician practicing in family practice, internal medicine, gynecology, obstetrics or pediatrics and who has agreed to assume primary responsibility for managing the Enrollee's medical care under the Group Contract.

Provider A doctor, Hospital, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized to provide Health Care Services pursuant to the law of the jurisdiction in which care or treatment is received including but not limited to an Independent Freestanding Emergency Department.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Routine Care Costs

The cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Care Costs do not include any of the following:

- The Health Care Service that is the subject of the Approved Clinical Trial.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
- Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
- An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
- Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where an Approved Clinical Trial is conducted.
- A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
- A Health Care Service that is eligible for reimbursement from a source other than this Group Contract, including the sponsor of the Approved Clinical Trial.

Serious and Complex Condition

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

(1) life-threatening, degenerative, potentially disabling, or congenital; and

(2) requires specialized medical care over a prolonged period of time.

Skilled Nursing Facility

A Provider licensed under state law to provide Inpatient care for recovery from a Sickness or injury, supervised by a physician, providing 24 hour per day nursing care supervised by a full-time registered nurse, and not primarily custodial or domiciliary care.

Step Therapy Protocol

A protocol that sets forth an order in which certain Prescription Drugs must be used to treat an Enrollee’s condition.

Subscriber

An employee of the Employer who is eligible for and enrolled in coverage under the Group Contract.

Telehealth Services

Health Care Services delivered by use of interactive electronic communications and technology in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including:

1. Secure video conferencing;
2. Store and forward technology;
3. Remote patient monitoring technology;

	Between a Participating Provider in one location and a patient in another location and this is identified by us as secure and appropriate for use in the delivery of certain Health Care Services including, medical exams and consultations and Behavioral Health evaluations and treatment. For purposes of this definition, "store and forward technology" means transferring data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.
Urgent Care Claims	A request for a Health Care Service that, if subject to the time limits applicable to Post-Service Claims or Pre-Service Claims (as defined in Article 7 Section B) meets either of the following: • Would seriously jeopardize the Enrollee's life, health or ability to reach and maintain maximum function. • In the opinion of physicians familiar with the Enrollee's condition, would subject the Enrollee to severe pain that cannot be adequately managed unless we approve the Claim.
We/Us	Indiana University Health Plans, Inc.
You/Enrollee	The term "you" refers to you, the Subscriber. The term "Enrollee" refers to you, the Subscriber and your Dependents who are enrolled for coverage under the Group Contract.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits for the Indiana University Health Plans High Option 2023

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.iuhealthplans.org.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $25 primary care; $35 specialist	25
Services provided by a hospital: • Inpatient Facility	$250 Copayment per visit	47
Services provided by a hospital: • Outpatient Facility	$100 Copayment per visit	48
Emergency benefits: • In-area	$250 Copayment. Waived if admitted.	51
Emergency benefits: • Out-of-area	$250 Copayment.	51
Mental health and substance use disorder treatment: • PCP • Specialist • Inpatient • Diagnostic • Outpatient services	 • $25 copayment per visit • $35 Copayment per visit • $250 Copayment per visit • 10% Coinsurance after Deductible • $25 Copayment per visit	53

High Option Benefits	You pay	Page
Prescription drugs: • 5-Tier prescription drug benefit	Retail (30-day supply) • Tier 1 – (Preferred Generic) - $2 copayment when using IU Pharmacy $3 copayment when using CVS Caremark Advance Choice Pharmacies • Tier 2 – (Non-Preferred Generic) - $5 copayment when using IU Pharmacy $6 copayment when using CVS Caremark Advance Choice Pharmacies • Tier 3 – (Preferred Brand Name) – 25% coinsurance after the deductible using IU Pharmacy, 30% coinsurance after the deductible using CVS Caremark Advanced Choice Pharmacies • Tier 4 – (Non-Preferred Brand Name) – 45% coinsurance after the deductible using IU Pharmacy, 50% coinsurance after the deductible using CVS Caremark Advanced Choice Pharmacies • Tier 5 – (Specialty) – 45% coinsurance after the deductible. Limited to a 30-day supply. Maintenance (90-day supply) • Tier 1 (Preferred Generic) - $6 copayment using IU Pharmacy or CVS Caremark Advanced Choice Pharmacies • Tier 2 (Non-Preferred Generic) - $12 copayment using IU Pharmacy or CVS Caremark Advanced Choice Pharmacies • Tier 3 (Preferred Brand Name) – 30% coinsurance after the deductible using IU Pharmacy or CVS Caremark Advanced Choice Pharmacies • Tier 4 (Non-Preferred Brand Name) – 50% coinsurance after the deductible using IU Pharmacy or CVS Caremark Advanced Choice Pharmacies	57
Dental care: • Dental Services for Accidental Injury	10% Coinsurance after Deductible	62
Vision care: • Pediatric Vision (Benefits available for Enrollees until the first day of the month after they obtain the age of 19)	Pediatric vision, members pay nothing. Limited to one exam per calendar year. Treatment and supplies following surgery for cataracts, contact lenses or glasses (including bifocals) are covered. All other treatment and supplies are not covered.	32
Special features: Flexible benefits option, Clickotine Smoking Cessation, Travel and Out-of-Area Coverage, Services for the deaf and hearing-impaired, Telehealth, IU Health Maternity Program, IU Health Patient Portal,	Contact Plan at 866-895-5828	63

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $6,000/Self Only enrollment or $12,000/ Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection.	13

2023 Rate Information for the Indiana University Health Plans High Option

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Indiana					
High Option Self Only	FS1	$209.85	$69.95	$454.67	$151.56
High Option Self Plus One	FS3	$461.68	$153.89	$1,000.31	$333.43
High Option Self and Family	FS2	$587.58	$195.86	$1,273.09	$424.36