Filing at a Glance

Company:	IU Health Plans
Product Name:	IU Health Plans Individual Product
State:	Indiana
TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02I.005D Individual - HMO
Filing Type:	Form/Rate
Date Submitted:	05/09/2014
SERFF Tr Num:	IUHP-129535085
SERFF Status:	Closed-Approved
State Tr Num:	13164.1-INDIV-POLICY (01/2015)
State Status:	Closed
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Implementation Date Requested:	01/01/2015
Author(s):	Jennifer Pitzer, Joan Naffziger
Reviewer(s):	Paul Hyslop (primary), Karl Knable
Disposition Date:	08/08/2014
Disposition Status:	Approved
Implementation Date:	01/01/2015

State Filing Description:

General Information

Project Name: Marketplace Ind 2015
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Joan Naffziger

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Non Employer Group - Individual
Filing Status Changed: 08/08/2014
State Status Changed: 08/08/2014
Created By: Joan Naffziger
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: This submission includes both on-Exchange and off-Exchange Individual products.

Filing Description:

This submission has been prepared in accordance with the IU Health Plans' interpretation of the existing regulatory guidelines for Individual HMO products to be offered through the Indiana Health Insurance Marketplace. The plans included in the filing reflect state guidance and Patient Protection and Affordable Care Act (PPACA) provisions. The rates associated with this filing will be effective January 1, 2015.

Company and Contact

Filing Contact Information

Joan Naffziger, IS Operations Manager
950 N Meridian St
Suite 200
Indianapolis, IN 46204

jnaffzig@iuhealth.org
317-963-9760 [Phone]

Filing Company Information

IU Health Plans
1776 North Meridian Street
Suite 300
Indianapolis, IN 46202
(317) 963-9746 ext. [Phone]

CoCode: 13164
Group Code: 4637
Group Name: IU Health Plans
FEIN Number: 26-2127080

State of Domicile: Indiana
Company Type: HMO
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$105.00
Retaliatory?	No
Fee Explanation:	2 policy forms and 1 rate

SERFF Tracking #: IUHP-129535085 **State Tracking #:** 13164.1-INDIV-POLICY (01/2015) **Company Tracking #:**

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Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		IU Health Plans Individual Product	13164.1-Indiv-Policy(01/2015)	POL	Initial		51.500	IU Health Plans - Adult and Child Only Combined Policy _clean_06122014.pdf
2		IU Health Plans Individual Product	13164.1-Indiv-Policy-Child(01/2015)	POL	Other	Replace with combined policy	51.500	
3		IU Health Plans Individual Product	13164.1-Indiv-App-Adult/Child(01/2015)	AEF	Initial			IU Health Plans - Application - ADULT_CHILD _clean_06062014.pdf
4		IU Health Plans Bronze HSA Schedule of Benefits	13164.1-Indiv-Schedule Bronze HSA-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Bronze HSA_5.9.14.pdf
5		IU Health Plans Bronze Value Schedule of Benefits	13164.1-Indiv-Schedule Bronze V-Adult (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Bronze Value_5.9.14.pdf
6		IU Health Plans Bronze Enhanced Schedule of Benefits	13164.1-Indiv-Schedule Bronze E-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Bronze Enhanced_5.9.14.pdf

SERFF Tracking #: IUHP-129535085 **State Tracking #:** 13164.1-INDIV-POLICY (01/2015) **Company Tracking #:**

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
7		IU Health Plans Silver HSA Schedule of Benefits	13164.1-Indiv-Schedule Silver HSA(01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver HSA_5.9.14.pdf
8		IU Health Plans Silver Value Schedule of Benefits	13164.1-Indiv-Schedule Silver V (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Value_5.9.14.pdf
9		IU Health Plans Silver Enhanced Schedule of Benefits	13164.1-Indiv-Schedule Silver E(01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Enhanced_5.9.14.pdf
10		IU Health Plans Schedule of Benefits - Silver HSA 73	13164.1-Indiv-Schedule Silver HSA 73-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver HSA - CSR 73_8.1.14.pdf
11		IU Health Plans Schedule of Benefits - Silver Value 73	13164.1-Indiv-Schedule Silver V 73-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Value - CSR 73_8.1.14.pdf
12		IU Health Plans Schedule of Benefits - Silver Enhanced 73	13164.1-Indiv-Schedule Silver E 73-Adult/Child (01/2015)	SCH	Initial			IUHealthPlansScheduleofBenefits-SilverEnhanced-CSR73_5.27.14.pdf.pdf

SERFF Tracking #: IUHP-129535085 **State Tracking #:** 13164.1-INDIV-POLICY (01/2015) **Company Tracking #:**

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
13		IU Health Plans Schedule of Benefits - Silver HSA 87	13164.1-Indiv-Schedule Silver HSA 87-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver HSA - CSR 87_8.1.14.pdf
14		IU Health Plans Schedule of Benefits - Silver Value 87	13164.1-Indiv-Schedule Silver V 87-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Value - CSR 87_5.9.14.pdf
15		IU Health Plans Schedule of Benefits - Silver Enhanced 87	13164.1-Indiv-Schedule Silver E 87-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Enhanced - CSR 87_5.9.14.pdf
16		IU Health Plans Schedule of Benefits - Silver HSA 94	13164.1-Indiv-Schedule Silver HSA 94-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver HSA - CSR 94_5.9.14.pdf
17		IU Health Plans Schedule of Benefits - Silver Value 94	13164.1-Indiv-Schedule Silver V 94-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Value - CSR 94_5.9.14.pdf
18		IU Health Plans Schedule of Benefits - Silver Enhanced 94	13164.1-Indiv-Schedule Silver E 94-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Enhanced - CSR 94_8.1.14.pdf

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Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
19		IU Health Plans Schedule of Benefits - Gold Value	13164.1-Indiv-Schedule Gold-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Gold Value_5.9.14.pdf
20		IU Health Plans Schedule of Benefits - Bronze HSA - Limited Cost Sharing	13164.1-Indiv-Schedule Bronze HSA-LCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Bronze HSA - Limited Cost Sharing_5.9.14.pdf
21		IU Health Plans Schedule of Benefits - Bronze Value - Limited Cost Sharing	13164.1-Indiv-Schedule Bronze V-LCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Bronze Value - Limited Cost Sharing_5.9.14.pdf
22		IU Health Plans Schedule of Benefits - Bronze Enhanced - Limited Cost Sharing	13164.1-Indiv-Schedule Bronze E-LCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Bronze Enhanced - Limited Cost Sharing_5.9.14.pdf
23		IU Health Plans Schedule of Benefits - Silver HSA - Limited Cost Sharing	13164.1-Indiv-Schedule Silver HSA - LCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver HSA - Limited Cost Sharing_5.9.14.pdf

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
24		IU Health Plans Schedule of Benefits - Silver Value - Limited Cost Sharing	13164.1-Indiv-Schedule Silver V - LCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Value - Limited Cost Sharing_5.9.14.pdf
25		IU Health Plans Schedule of Benefits - Silver Enhanced - Limited Cost Sharing	13164.1-Indiv-Schedule Silver E - LCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Enhanced - Limited Cost Sharing_5.9.14.pdf
26		IU Health Plans Schedule of Benefits - Gold Value - Limited Cost Sharing	13164.1-Indiv-Schedule Gold Value-LCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Gold Value - Limited Cost Sharing_5.9.14.pdf
27		IU Health Plans Schedule of Benefits - Bronze HSA - Zero Cost Sharing	13164.1-Indiv-Schedule Bronze HSA-ZCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Bronze HSA - Zero Cost Sharing_5.9.14.pdf
28		IU Health Plans Schedule of Benefits - Bronze Value - Zero Cost Sharing	13164.1-Indiv-Schedule Bronze V-ZCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Bronze Value - Zero Cost Sharing_5.9.14.pdf

SERFF Tracking #: IUHP-129535085 **State Tracking #:** 13164.1-INDIV-POLICY (01/2015) **Company Tracking #:**

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
29		IU Health Plans Schedule of Benefits - Bronze Enhanced - Zero Cost Sharing	13164.1-Indiv-Schedule Bronze E-ZCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Bronze Enhanced - Zero Cost Sharing_5.9.14.pdf
30		IU Health Plans Schedule of Benefits - Silver HSA - Zero Cost Sharing	13164.1-Indiv-Schedule Silver HSA - ZCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver HSA - Zero Cost Sharing_5.9.14.pdf
31		IU Health Plans Schedule of Benefits - Silver Value - Zero Cost Sharing	13164.1-Indiv-Schedule Silver V - ZCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Value - Zero Cost Sharing_5.9.14.pdf
32		IU Health Plans Schedule of Benefits - Silver Enhanced - Zero Cost Sharing	13164.1-Indiv-Schedule Silver E - ZCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Silver Enhanced - Zero Cost Sharing_5.9.14.pdf
33		IU Health Plans Schedule of Benefits - Gold Value - Zero Cost Sharing	13164.1-Indiv-Schedule Gold Value-ZCS-Adult/Child (01/2015)	SCH	Initial			IU Health Plans Schedule of Benefits - Gold Value - Zero Cost Sharing_5.9.14.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form

State: *Indiana* **Filing Company:** *IU Health Plans*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *IU Health Plans Individual Product*
Project Name/Number: *Marketplace Ind 2015/*

CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

[Insert logo left/center/right]

[INDIVIDUAL] [CHILD-ONLY] CONTRACT
[Issued through the Indiana Marketplace]
(herein called the "Contract")

[Product Name]

Issued by:

Indiana University Health Plans, Inc.
an Indiana domestic health maintenance organization
950 North Meridian Street
Indianapolis, Indiana 46204

[This coverage is issued through the Indiana Marketplace] [to provide coverage for a Dependent]. This Contract sets forth in detail [your] [the] rights and obligations [as a] [of the] Subscriber. It is important that you **read this Contract carefully.** [This Contract provides coverage only for enrolled Dependents.] This Contract includes limitations and exclusions. You should familiarize yourself with its terms and conditions before receiving Health Care Services. Capitalized terms have the meaning set forth in the Definitions sections.

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, you may return it to us or the agent who sold it to you within 10 days after your receipt. Your premium will be refunded and this Contract with be void from its start. Any Health Care Services received during this 10-day period are solely your responsibility.

Benefits under this Contract may vary depending on other medical expense insurance you may have.

If you have questions related to [your] [the] health insurance coverage [provided under this Contract], you may contact us at [toll free number] [or the Indiana Marketplace at www.healthcare.gov or [toll free number].]

[signature]
President

[**DISCLAIMER:** The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace.]

TABLE OF CONTENTS **PAGE**

ARTICLE 1. DEFINITIONS 1
ARTICLE 2. ELIGIBILITY AND ENROLLMENT. 9
ARTICLE 3. YOUR FINANCIAL OBLIGATIONS 16
ARTICLE 4. COVERED SERVICES 19
ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS 54
ARTICLE 6. OBTAINING COVERED SERVICES 63
ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES. 65
ARTICLE 8. PAYMENT FOR COVERED SERVICES 74
ARTICLE 9. COORDINATION OF BENEFITS 76
ARTICLE 10. TERMINATION OF COVERAGE 81
ARTICLE 11. GENERAL PROVISIONS 86

ARTICLE 1. DEFINITIONS

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, [Dependent or Covered Person, either collectively or individually as appropriate to the reference] [who obtained this coverage through the Indiana Marketplace.]

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber [or the Dependent or Covered Person, either collectively or individually as appropriate to the reference].]

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.

Approved Clinical Trial – a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

(a) A trial that is approved or funded by one, or a combination, of the following.

(a) The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services.

(b) The United States Food and Drug Administration.

(c) The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(d) The United States Department of Veteran’s Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(e) The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).

(f) The Centers for Disease Control and Prevention.

(g) The Agency for Health Care Research and Quality.

(h) The Centers for Medicare and Medicaid Services (CMS).

(i) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks.

(j) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(k) A qualified non-governmental research entity in guidelines issued by the National Institutes of Health for center support grants.

(2) A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.

(3) A study or investigation done for drug trials which are exempt from the investigational new drug application.

For purposes of this definition, the term "life threatening condition" means any disease or condition from which death is likely unless the disease of condition is treated.

Behavioral Health – a physical or behavioral condition having an emotional or psychological origin or effect, including substance abuse. Behavioral Health Services include mental health services and substance abuse services.

Benefits – your right to payment for Covered Services under this Contract subject to the terms, conditions, limitations, and exclusions of this Contract.

Child or Children – a child of the Subscriber or Subscriber's spouse, including any of the following until the Child attains the age of [26] [21].

- Natural child,
- Stepchild,
- Legally adopted child,
- Child placed for the purpose of adoption, or
- Child placed under legal guardianship or legal custody.

Child includes a child of any age who is incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 26 and the Subscriber principally supports the Child. Proof of the disability must be submitted to us within thirty-one (31) days of the child's [26th] [21st] birthday. For two years we may require proof of the child's continuing disability and dependency at reasonable intervals. After two years, we may require proof of the child's disability and dependency no more than once per year.

Coinsurance – a percentage of the Allowed Amount that [you] [the Subscriber] must pay for certain Covered Services. Coinsurance amounts are set forth in the Schedule of Benefits.

Contract – this individual contract issued by Indiana University Health Plans, Inc. which provides Benefits for Covered Services received by [the Subscriber] and enrolled Dependents. The term Contract includes the Schedule of Benefits, any application, amendments and riders.

Copayment – a fixed amount [you pay] [the Subscriber pays] to a Provider for a Covered Service. The amount of a Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

Cosmetic Services – Health Care Services primarily intended to preserve, change or improve [your] [a Covered Person's] appearance or are furnished for psychiatric or psychological reasons.

Cost Sharing – the amount you are required to pay for Covered Services. Cost Sharing can be in the form of Copayments, Coinsurance or Deductibles.

Covered Person – [you or] any Dependent who meets all applicable eligibility requirements for coverage under this Contract, is enrolled as provided in this Contract, and for whom the required premium payment has been received by us.

Covered Services – Health Care Services [provided to a Covered Person] performed, prescribed, directed or authorized by a Provider and for which this 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 this Contract is in force.
- Not experimental/investigative.
- Authorized in advance by us if Precertification is required under this Contract.
- Not excluded or limited by this Contract.

Deductible – the amount [you] [the Subscriber] must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The amount of the Deductible is set forth in the Schedule of Benefits.

Dependent – an individual who [is either the Subscriber's legal spouse or a Child] [satisfies the eligibility requirements to enroll as a Dependent as set forth in Article 2].

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 [website] 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.

Durable Medical Equipment – Medical equipment that:

- can withstand repeated use and is not disposable,
- is used to serve a medical purpose,
- is generally not useful to a person in the absence of a Sickness or injury,
- is appropriate for use in the home, and
- is the most cost-effective type of medical apparatus appropriate for the condition.

Effective Date – the date when coverage under this Contract begins.

Emergency Medical Condition or Emergency – a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent 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 woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to a person's bodily functions.
- Serious dysfunction of a bodily organ or part of a person.

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, 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, 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 woman 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 woman or the unborn child.

FDA – the United States Food and Drug Administration.

Grace Period – the time period for payment of premium set forth in Article 3 Section B.

Health Care Services – medical or health care services, whether or not covered under this 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.

Indiana Marketplace – the health benefit exchange established by the Affordable Care Act for the state of Indiana.

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

Medically Necessary – those Health Care Services that we determine to be all of the following.

(4) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for [your] [the Covered Person's] illness, injury or disease.

(5) Required for the direct care and treatment or management of [your] [the Covered Person's] illness, injury or disease.

(6) If not provided, [your] [the Covered Person's] condition would be adversely affected.

(7) Provided in accordance with generally accepted standards of medical practice.

(8) Not primarily for the convenience of [you] [the Covered Person], your family, the physician or another prescribing Provider.

(9) 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 [your] [the Covered Person'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 [your] [the Covered Person'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 used in this 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 – 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 this Contract.

Non-Participating Hospital – a Hospital that has not entered into a contractual agreement with us or is not otherwise engaged by us to provide Health Care Services to Covered Persons under this 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 Covered Persons under this Contract.

[**Open Enrollment Period** – the number of days each year during which individuals may enroll in a Qualified Health Plan through the Indiana Marketplace.]

[**Open Enrollment Period** – the number of days each year during which individuals may enroll for coverage under this Contract.]

Out of Pocket Maximum – the maximum amount you will pay for Covered Services in a Plan Year.

Outpatient – receipt of Health Care Services while not an Inpatient.

Participating Hospital – a Hospital 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 Covered Persons under this Contract.

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 Covered Persons under this Contract.

Plan Year – the calendar year during which this Contract is in effect. This Plan Year will be the 12 month calendar year except that if the Subscriber's Effective Date is after January 1st the Plan Year will begin on the Effective Date and end December 31st.

Precertification – 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.

Prescription Drug – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product, insulin, diabetic supplies, and syringes.

Prescription Legend Drug – A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

Primary Care Physician or 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 [your] [a Covered Person's] medical care under this Contract.

Provider – a doctor, Hospital, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

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.

(1) The Health Care Service that is the subject of the Approved Clinical Trial.

(2) 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.

(3) 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.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) 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.

(6) A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.

(7) A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Qualified Health Plan – a health plan offered on the Indiana Marketplace that satisfies the requirements set forth under the Affordable Care Act (42 U.S.C. 18021(a)(1)).

[**Qualified Individual** – an individual who has been determined by the Indiana Marketplace to be eligible to enroll in a Qualified Health Plan.]

Schedule of Benefits – the part of this Contract that sets forth Cost Sharing, Out of Pocket Maximums, limitations and other information regarding [your] [a Covered Person's] coverage under this Contract.

Service Area – the counties in which we are authorized to offer a qualified health plan. Our Service Area is [insert list of counties].

Sickness – an illness, disorder, or disease.

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.

[**Special Enrollment Periods** – enrollment periods administered by the Indiana Marketplace that occur outside of the Open Enrollment Period. Qualified Individuals and their dependents who are eligible for a Special Enrollment Period may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another during a Special Enrollment Period set for them by the Indiana Marketplace.]

[**Special Enrollment Periods** – enrollment periods administered by us that occur outside of the Open Enrollment Period.]

Spouse – the Subscriber's legal spouse.

[**Subscriber** – an individual whose name is on the Contract and has enrolled a Dependent for coverage under this Contract. A Subscriber is the legal parent or legal guardian of the Covered Person. The Subscriber is not a Covered Person under this Contract.]

Therapeutic Abortion – an abortion performed to save the life or health of the mother, or as a result of incest or rape

Urgent Care Claim – 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 [your] [a Covered Person's] life, health or ability to reach and maintain maximum function.
- In the opinion of physicians familiar with [your] [a Covered Person's] condition, would subject [you] [a Covered Person] to severe pain that cannot be adequately managed unless we approve the Claim.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT.

[This Contract is available through the Indiana Marketplace. The Benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Indiana Marketplace to be Qualified Individuals.]

A. **[You][The Covered Person] as an Individual.** To be eligible for coverage as a Subscriber, an individual must meet the eligibility requirements listed below at the time of application and throughout the Plan Year.[Determined by the Indiana Marketplace to be a Qualified Individual for purposes of enrollment in a Qualified Health Plan.] [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective.]

(2) [Not incarcerated.] [Agree to pay the cost of the Premium that we require.]

(3) [A United States citizen or lawfully present non-citizen.] [Submit proof satisfactory to us to confirm Dependent eligibility.]

(4) [To be eligible as a Dependent, the person must be the Subscriber's Child.]

(5) [Under age 21.]

(6) A resident of the State of Indiana.

(7) Not entitled to or enrolled in Medicare or Medicaid.

(8) Not covered by any other group or individual health benefit plan.

B. [**Your Dependents.** To be eligible as a Dependent, another person must either be your Spouse or your Child.]

C. [**Other Rules About Eligibility.** No one will be denied enrollment or re-enrollment in this Contract because of health status, or the existence of a pre-existing physical or mental condition.]

D. **Open Enrollment.**

(1) [Notice of Annual Open Enrollment. Each calendar year the Indiana Marketplace will provide you with a written annual open enrollment notification no earlier than September 1, and no later than September 30.]

[Notice of Annual Open Enrollment. Each calendar year we will provide you with a prior written notice of the Open Enrollment Period.]

(2) [2015 Open Enrollment Period. For this Plan Year beginning on January 1, 2015, the Open Enrollment period begins on November 15, 2014 and extends through February 15, 2015.]

(3) [Effective Dates for Coverage Selected During 2015 Open Enrollment. For this Plan Year beginning on January 1, 2015, the following Effective Dates will apply:

(a) January 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace on or before December 15, 2014.

(b) February 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from December 16, 2014 through January 15, 2015.

(c) March 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from January 16, 2015 through February 15, 2015.]

(4) [Effective Dates for Coverage Selected During Annual Open Enrollment. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if we receive the application and initial premium payment between the 1st and 15th of the month. If we receive the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st)]

E. [**Special Enrollment Period.**

(1) Special Enrollment Triggering Events. The Indiana Marketplace must allow Qualified Individuals and [their] Dependents to enroll in a Qualified Health Plan or change from one Qualified Health Plan to another as a result of experiencing any of the following triggering events:

(a) Loss of Minimum Essential Coverage.

(b) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(c) Gaining status as a citizen, national, or lawfully present individual.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services ("HHS"), or its instrumentalities as evaluated and determined by the Indiana Marketplace. In such cases, the Indiana Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to a new service area of the Indiana Marketplace.

(h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(i) Demonstration to the Indiana Marketplace, in accordance with guidelines issued by HHS, that [you or your] [the] Dependent meets other exceptional circumstances as the Indiana Marketplace may provide.

(j) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.)

(2) Indiana Marketplace Administration of Special Enrollments. For additional information on special enrollment triggering events and how to enroll in or change a Qualified Health Plan during a Special Enrollment Period, you should contact the Indiana Marketplace at [toll free number] or visit the Indiana Marketplace website at [www.healthcare.gov].

(3) Notice Requirement for Special Enrollments. Unless specifically stated otherwise in the applicable Indiana Marketplace rules, a [Qualified Individual or Dependent] [person] has sixty (60) days from the date of a special enrollment triggering event to select a Qualified Health Plan.

(4) Special Enrollment Effective Dates. The Effective Date for coverage obtained under this Contract during a Special Enrollment Period depends on the type of triggering event that qualified the individual and/or dependent for the Special Enrollment Period as well as the date the Indiana Marketplace received the Qualified Individual's Qualified Health Plan selection.

(a) For a Qualified Health Plan selection received from the first (1st) through the fifteenth (15th) day of any month, the Effective Date will be the first (1st) day of the following month; and

(b) For a Qualified Health Plan selection received from the sixteenth (16th) through the last day of any month, the Effective Date will be the first (1st) day of the second following month.]

E. [**Changes Affecting Eligibility and Special Enrollment Periods.**

(1) Special Enrollment Triggering Events. A Special Enrollment Period is a period during which an eligible individual who experiences certain triggering events or changes in eligibility may enroll in this Contract, outside of the Open Enrollment period.

(2) Length of Special Enrollment Period. Unless otherwise stated, an eligible individual has 60 days from the date of a triggering event to enroll an eligible individual in this Contract.

(3) Triggering Events.

(a) Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, misrepresentation of a material fact or failure to pay premium.

(b) Loss of Minimum Essential Coverage due to dissolution of marriage.

(c) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Indiana Marketplace.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to new service area of the Indiana Marketplace.

(h) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.]

F. Adding New Dependents Under A Special Enrollment Period.

(1) Newly Born Children. If [you have] [the Subscriber has] a new Dependent as a result of birth, coverage for [your] [the] new Dependent is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for [your] [the] new Dependent shall continue beyond the initial thirty-one (31) days, provided [you request] [the Subscriber requests] [a Special Enrollment Period through the Indiana Marketplace to add [your] [the] new Dependent to this Contract] [you submit] [the Subscriber submits] [a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, if any[, within 60 days after the birth of the new Dependent]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days after the date of birth. The Effective Date will be the date of birth.]

[If a Covered Person has a newborn child, coverage for the newborn child is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for the newborn child shall continue beyond the initial thirty-one (31) days, provided the newborn child meets the definition of Child under this Policy and the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace] [submits a form to us] to add the Child to this Contract and we receive payment for additional applicable premium, if any. If the newborn child does not meet the definition of Child under this Policy before the end of the initial thirty-one (31) days, coverage for the newborn child will terminate upon the thirty-second (32nd) day.]

(2) Adopted Children. If [you have] [the Subscriber has] a new Dependent as a result of adoption, coverage for [your] [the] new Dependent is automatically provided from the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting [you] [the Subscriber] custody of the child for purposes of adoption, for up to thirty-one (31) days. Coverage for [your] [the] new Dependent shall continue beyond the initial thirty-one (31) day period provided [you request] [the Subscriber requests] [a Special Enrollment Period through the Indiana Marketplace to add [your] [the] new Dependent to this Contract] [you submit] [the Subscriber submits] [a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, in any[, within 60 days following the date of adoption or placement for adoption]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of adoption or placement of adoption.] The Effective Date will be the earlier of the date of adoption or placement of adoption.

(3) Adding a Child due to Award of Guardianship. If [you] [the Subscriber] or [your] [the Subscriber's] spouse files an application for an appointment of guardianship for a Child, an application to cover the Child under this Contract must be submitted to [the Indiana Marketplace] [us] within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

(4) Qualified Medical Child Support Order. If [you are] [the Subscriber is] required by a Qualified Child Support Order or court order, as defined by applicable state and federal law, to enroll [your] [his or her] Child under this Contract, and the Child is otherwise eligible for the coverage, [the Indiana Marketplace] [we] will permit [your] [the Subscriber's] Child to enroll in this Contract, and we will provide the benefits of this Contract in accordance with the applicable requirements of such court order.

A Child's coverage under this provision will not extend beyond the Dependent attaining age [26] [21]. Any claims payable under this Contract will be paid, at our discretion, to the Child or the Child's custodial parent or legal guardian, for any expenses paid by the Child, custodial parent or legal guardian. We will make information available to the Child, custodial parent or legal guardian on how to obtain benefits and submit claims to us directly.

(5) [Spouse] [New Dependent as a Result of Marriage] or Loss of Minimum Essential Coverage. If [you have] [the Subscriber has] a new Dependent as a result of marriage, or due to [your] [the] new Dependent's loss of Minimum Essential Coverage, [you] [the Subscriber] may elect to enroll [your] [the] new Dependent in this Contract, provided [you [request] [the Subscriber requests] [a Special Enrollment Period from the Indiana Marketplace to add your new Dependent to this Contract] [you submit] [the Subscriber submits] [to us a form to add your new Dependent] and we receive payment for additional applicable premium, if any[, within 60 days from the date of marriage or the loss of Minimum Essential Coverage]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of marriage or the loss of Minimum Essential Coverage.] The Effective Date will be on the first (1st) day of the month following the date of marriage or loss of Minimum Essential coverage.

(a) "Loss of Minimum Essential Coverage" includes loss of eligibility for coverage as a result of any of the following:

(a) Legal separation or divorce.

(b) Cessation of dependent status (such as reaching the maximum age to be eligible as a Dependent under this Contract).

(c) Death of an employee; termination of employment; reduction in the number of hours of employment; or any loss of eligibility for coverage after a period that is measured by any of the foregoing.

(d) Individual who no longer resides, lives or works in the service area.

(e) A situation in which a health benefit plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Termination of employer contributions.

(g) Exhaustion of COBRA continuation of coverage.

(b) "Loss of Minimum Essential Coverage" does not include termination or loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(b) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact

If [you do] [the Subscriber does] not enroll [your] [a] new Dependent during the time periods stated above, [he or she] [the new Dependent] will not be added to [your] [the] coverage [under this Contract] until the next Open Enrollment Period.

G. Notification of Changes.

(1) Responsibility to Notify [the Indiana Marketplace] [Us]. [You are] [The Subscriber is] required to notify [the Indiana Marketplace] [us] of any changes in [your] [a Covered Person's] eligibility [or the eligibility of your Dependents] for Benefits under this Contract. [The Indiana Marketplace] [We] must be notified of any changes in eligibility as soon as possible, but not later than thirty (30) days from the date of the change in eligibility status. This may include changes in address, marriage, divorce, death, incarceration, change of Dependent disability or dependency status, change in Medicare or Medicaid eligibility status, etc. Notice of a change in eligibility must be provided to [the Indiana Marketplace in a form required and approved by the Indiana Marketplace] [us in writing and on a form approved by us]. Such notifications must include all information required to effectuate all necessary changes.

(2) Failure to Notify [Indiana Marketplace] [Us]. Failure to notify [the Indiana Marketplace] [us] of persons no longer eligible for coverage under this Contract will not obligate us to provide services to those no longer eligible. Our acceptance of payments for persons no longer eligible for services will not obligate us to pay for such services.

(3) Effective Date of Termination Due to Change in Eligibility. Regardless of whether we receive timely notice, a Covered Person's coverage will terminate on the [last day of the month following the date] [day] such Covered Person ceases to be eligible for coverage under this Contract. [We have the right to bill [you] [the Subscriber] for the cost of any Health Care Services provided to a Covered Person during the period such Covered Person is not eligible under this Contract.] If [you think] [the Subscriber thinks] there are reasons coverage of the person experiencing the change should continue, [you] [the Subscriber] must notify [the Indiana Marketplace] [us] of the reasons for the continuation of the coverage no later than thirty-one (31) days after the date coverage for the Dependent would otherwise terminate.

(4) [Statements and Forms. You shall complete and submit to us applications and other forms or statements we may request. You represent to the best of their knowledge and belief that all information contained in such applications, forms, questionnaires, and statements submitted to us is true, correct and complete. You understand that all rights to Benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you or a Covered Person may result in termination or rescission of coverage.]

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A. Premium.

(1) [You] [The Subscriber] must pay premium to us each month for coverage under this Contract. [Your] [The Subscriber's] premium rate is determined using the following acceptable rating factors: age, tobacco use, family size and geography.

(a) Tobacco use impacts the determination of [your] [the] premium. [Upon enrollment through the Indiana Marketplace] [During the enrollment application process], [you] [the Subscriber] will attest to tobacco use by [you and/or you] [his and/or her Dependents]. If [you report] [the Subscriber reports] false or incorrect information about tobacco use, we may retroactively apply the appropriate tobacco rating factor to [your] [the Subscriber's] premium as if the correct information had been accurately reported from the Effective Date.

(b) [Your] [A Covered Person's] age impacts the determination of [your] [the] premium rate. If [your] [a Covered Person's] age has been misstated, we will adjust the premiums to the amount premiums would have been if purchased at the correct age.

(2) [You] [The Subscriber] will receive a monthly bill for your premium. [Your] [The Subscriber's] payment is due by the date stated in [your] [the Subscriber's] bill subject to the any applicable Grace Period stated in this Contract. [You] [The Subscriber] must pay [your] [the] premium when it is due for coverage to continue.

(3) We reserve the right to change the premium on an annual basis. We will provide [you] [the Subscriber] with thirty (30) days prior written notice of any change in the premium.

(4) [Your] [The Subscriber's] premium may change if Dependents are enrolled or disenrolled in [your] [the] coverage [under this Contract]. If a premium increase is necessary, we will bill [you] [the Subscriber] for the additional amount due. If this amount is not paid, this Contract will be cancelled at the end of the applicable Grace Period and [you] [the Subscriber] will receive a refund of any unearned premium. If a decrease in premium is appropriate we will notify [you] [the Subscriber] of the decrease and refund any excess premium to [you] [the Subscriber].

(5) If premium has been paid for any period of time after the date [you cancel] [the Subscriber cancels] this Contract, we will refund that premium to [you] [the Subscriber]. The refund will be for the period of time after [your] coverage [under this Contract] ends. If a Covered Person dies while this Contract is in force, we will refund any premium paid for such Covered Person for any period after the date of the Covered Person's death [to you or your estate].

B. Grace Period.

(1) [General Grace Period.] Following payment of the initial premium, a Grace Period of thirty (30) days shall be granted for the payment of any premium. This Grace Period shall not extend beyond the date this Contract terminates. During the Grace Period this Contract shall continue in force. Any claims incurred and submitted during the Grace Period will not be considered for payment until premium is received. If premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of coverage.

(2) [Grace Period for Persons Receiving Advance Payments of the Premium Tax Credit. [If you are] [If the Subscriber or Covered Person is] receiving advance payments of the premium tax credit and at least one full month's premium has been paid during this Plan Year, a Grace Period of three (3) consecutive months shall be granted for the payment of any premium. During this 3-month Grace Period, we shall do all of the following listed below.

(a) Pay for Covered Services during the first (1st) month of the Grace Period and may pend claims for Covered Services rendered to [you] [the Covered Person] in the second and third months of the Grace Period.

(b) Notify the Department of Health and Human Services of such non-payment

(c) Notify Providers of the possibility for denied claims during the second and third months of the Grace Period.]

C. Deductible.

(1) The Deductible is the amount [you] [the Subscriber] must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The Deductible is set forth in the Schedule of Benefits.

(2) Copayments do not count towards the Deductible.

D. Coinsurance.

(1) Coinsurance is a percentage of the Allowed Amount that [you] [the Subscriber] must pay for Covered Services. [You are] [The Subscriber is] responsible for payment of Coinsurance after [you have] [the Subscriber has] met the Deductible and until [you reach] [the Subscriber reaches] the Out of Pocket Maximum. Coinsurance is set forth in the Schedule of Benefits.

(2) [Your] Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

E. Copayments.

(1) Copayments are a fixed amount [you pay] [the Subscriber pays] to a Provider for a Covered Service. Copayments are typically paid when [you receive] [the

Subscriber receives] the Covered Service. The amount of the Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

(2) Copayments do not apply to the Deductible. Copayments apply towards the Out of Pocket Maximum.

F. Out of Pocket Maximum.

(1) The Out of Pocket Maximum is the maximum amount [you] [the Subscriber] will pay for Covered Services in a Plan Year. The Out of Pocket Maximum is listed on the Schedule of Benefits.

(2) Once the Out of Pocket Maximum is reached, we will pay 100% of the Benefits for Covered Services.

(3) Copayments, Coinsurance and the Deductible apply towards the Out of Pocket Maximum.

G. Payments for Non-Covered Services. [You are] [The Subscriber is] responsible for payment of all expenses for Non-Covered Services.

ARTICLE 4. COVERED SERVICES

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides Benefits for the following Covered Services. Payment for Covered Services is limited by any applicable Coinsurance, Copayment, or Deductible set forth in this Contract including the Schedule of Benefits. To receive maximum Benefits for Covered Services, [you must follow] the terms of this Contract [must be followed], including receipt of care from a Primary Care Physician and Participating Providers as well as obtaining any required Precertification.

You are responsible for all expenses incurred for Non-Covered Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

A. Ambulance Services.

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

(a) From your home, scene of accident or medical Emergency to a Hospital,

(b) Between Hospitals,

(c) Between a Hospital and Skilled Nursing Facility, or

(d) From a Hospital or Skilled Nursing Facility to your home.

(2) Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

(3) Other vehicles which do not meet the definition of Ambulance Services are not Covered Services. Ambulette services are Covered Services when appropriate.

(4) Ambulance Services are a Covered Service only when Medically Necessary, except:

(a) When ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse, or

(b) When a Covered Person is required by us to move from a Non-Participating Provider to a Participating Provider.

(5) Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health.

(6) Non-Covered Services for Ambulance include but are not limited to:

(a) A trip to a physician's office or clinic,

(b) A trip to a morgue or funeral home, or

(c) Any ambulance usage for the convenience of a Covered Person, family or Provider.

B. Behavioral Health Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Covered Services include:

(a) Inpatient services. Individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

(b) Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

(c) Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health conditions. Intensive Outpatient programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient programs may offer group, DBT, individual, and family services.

(d) Outpatient Treatment, or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

(2) Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

(3) To assist you in obtaining appropriate and quality care, we will ask for a treatment plan after you have been evaluated after 10 Outpatient visits. We may discuss the goals of treatment and changes in the treatment plan, including

alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

(4) Non-Covered Services include the following.

(a) Custodial or domiciliary care.

(b) Supervised living or halfway houses.

(c) Services or care provided or billed by a residential treatment center, school, halfway house.

(d) Custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(e) Services related to non-compliance of care if the Covered Person ends treatment for substance abuse against the medical advice of the Provider.

C. Routine Care Costs as Part of a Cancer or Other Life Threatening Disease or Condition Clinical Trial.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits are available for Routine Care Costs rendered as part of an Approved Clinical Trial if the services are otherwise Covered Services under this Contract.

(2) Your Primary Care Physician must give us notice of your participation in an Approved Clinical Trial.

(2) Non-Covered Services include the following.

(a) A Health Care Service that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient.

(b) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service or investigational drug that is the subject of the clinical trial.

(c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.

(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the clinical trial.

(e) An item or drug provided by the clinical trial sponsors free of charge for any patient.

(f) A service, item, or drug that is eligible for reimbursement by a person or entity other than us, including the sponsor of the clinical trial.

D. Dental Services Related to an Injury.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient services, Physician Home Visits and Office Services, Emergency Services and Urgent Care Center Services for dental work and oral surgery are Covered Services if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Covered Person's condition.

(2) Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

(3) For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

(4) Covered Services include, but are not limited to the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations
- Prosthetic services
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia

(5) Anesthesia and Hospital charges for dental care for a Covered Person less than 19 years of age or a Covered Person who is physically or mentally disabled, are covered if the Covered Person requires dental treatment to be given in a Hospital or Outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Covered Person's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

E. Diabetic Equipment, Education and Supplies.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when ordered in writing by a physician or a podiatrist and provided by a physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

(2) Covered Services include physician prescribed equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances”, “Preventive Care Services”, and “Physician Home Visits and Office Services”.

F. Diagnostic Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services include the following.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).

- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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

(3) For Diagnostic services other than those approved to be received in a physician's office, you may be required to use a laboratory that is a Participating Provider.

(4) When Diagnostic radiology is performed in a Participating Provider's Office, no Copayment is required, however, any Coinsurance will still apply.

G. Emergency Care Services and Urgent Care Center Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit limitation. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits for treatment of an Emergency Medical Condition and Emergency screening and stabilization services without Precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions.

(2) Benefits for Emergency Care include facility costs and physician services, supplies and Prescription Drugs charged by that facility.

(3) Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Copayment or Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify us or verify that your physician has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary. If your Provider is a Non-Participating Provider, you will be financially responsible for any care we determine is not Medically Necessary.

(4) Often an urgent rather than an Emergency Medical Condition exists. An urgent medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Such medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Primary Care Physician prior to receiving care for an urgent medical problem and your Primary Care Physician

authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Care Services.

H. Home Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Covered Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Care Services.
- Nutritional Guidance.
- Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Health Care Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Care Services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services in the home (except for Massage, Music, and Manipulation Therapy). Home Care visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

(3) Non Covered Services include the following.

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

(4) Home infusion therapy will be paid only if you obtain Precertification. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

I. Hospice Services.

For all Covered Services, see the schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit limitations. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) 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 (6) months or less, as certified by the attending physician and hospice medical director. Covered Services will continue if the Covered Person lives longer than six (6) months, provided the hospice medical director or other hospice physician recertifies that the Covered Person is terminally ill.

(2) Covered Hospice Services include the following.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Care Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

(3) Non-Covered Services include services provided by volunteers and housekeeping services.

J. Inpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Inpatient services include the following.

(a) Charges from a Hospital, Skilled Nursing Facility or other Provider for room, board and general nursing services.

(b) Ancillary services.

(c) Professional services from a physician while an Inpatient.

(2) Room, Board, and General Nursing Services include either of the following.

(a) A room with two or more beds or a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

(b) A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

(3) Ancillary (Related) Services include any of the following.

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

(4) Professional Services include the following.

- Medical care visits limited to one visit per day by any one physician.
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, and EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

(5) When a Covered Person is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

K. Maternity Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

(2) If the Covered Person is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider for the Health Care Services to be Covered Services. If the Covered Person is pregnant on her Effective Date and is in her second or third trimester of pregnancy, she may receive Benefits for Health Care Services from a Non-Participating Provider if she requests and receives written approval from us.

(3) If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance or Copayment.

(4) If Maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

(5) Coverage for the Inpatient postpartum stay for a Covered Person and her newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if both or the following are met.

(a) In the opinion of your attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the following.

- The antepartum, intrapartum, and postpartum course of the mother and infant.
- The gestational stage, birth weight, and clinical condition of the infant.
- The demonstrated ability of the mother to care for the infant after discharge.
- The availability of post discharge follow-up to verify the condition of the infant after discharge.

(b) The mother of the newborn child agrees with the recommendation for a shorter length of stay.

(6) Covered Services include at-home post-delivery care visits at your residence by a physician or nurse performed no later than 48 hours following discharge from the Hospital. Coverage for this visit includes, but is not limited to parent education, assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At your discretion, this visit may occur at the physician's office.

(7) Covered Services include the following tests and examinations given at the earliest feasible time to the newborn child for the detection of the following disorders.

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

L. Medical Supplies, Durable Medical Equipment and Appliances.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Medical and Surgical Supplies. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a physician's office, including but not limited to, Depo-Provera and Remicade. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

(a) Covered Services include the following.

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.

- Clinitest.
- Needles/syringes.
- Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not Covered Services.

(b) Non-Covered Services include the following.

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Medijectors.

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

(3) Durable Medical Equipment - The rental (or, at our option, the purchase) of Durable Medical Equipment prescribed by a Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples of Durable Medical Equipment include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price.

(a) We will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Covered Person, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is a Covered Service.

(b) Covered Services include the following.

- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pump for IV fluids and medicine.
- Glucometer.

- Tracheotomy tube.
- Cardiac, neonatal and sleep apnea monitors.
- Augmentive communication devices are Covered Services when we approve based on the Covered Person's condition.
- CPAP machines when indicated for sleep apnea.

(c) Non-Covered Services include the following.

- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats.
- Rental of equipment if the Covered Person is in a Facility that is expected to provide such equipment.
- Translift chairs.
- Treadmill exerciser.
- Tub chair used in shower.

(4) Prosthetics. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

(a) Prosthetic devices should be purchased not rented. Applicable taxes, shipping and handling are Covered Services.

(b) Covered Services include the following.

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Plan Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction

is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered Services. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be a Covered Service.

- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Plan Year).

(c) Non-Covered Services include the following.

- Dentures, replacing teeth or structures directly supporting teeth.
- 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.

(5) Orthotic Devices. The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered Services. The casting is a Covered Service when an orthotic appliance is billed with it, but not if billed separately.

(a) Covered Services include the following.

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

(b) Orthotic appliances may be replaced one time per Plan Year unless specifically approved in writing by us. Additional replacements will be allowed for Covered Persons under age 18 due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

(c) Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

(d) Non-Covered Services include the following.

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

(6) Prosthetic limbs & Orthotic custom fabricated brace or support. Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be a Covered Service if they are determined by your physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities, and are not solely for comfort or convenience.

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

(b) Prosthetic limbs and orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

(7) Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below, as approved by us.

(a) The repair, adjustment or replacement of the purchased equipment, supply or appliance is a Covered Service if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.

- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

(b) Replacement of purchased equipment, supplies or appliance may be a Covered Service if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

(c) Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

M. Outpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital or other facility as determined by us. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation.

(2) Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to Article 3 Section B for Behavioral Health Services covered by this Contract.

(3) Professional charges only include services billed by a physician or other professional.

(4) When Diagnostic Services or other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Service, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

(5) For Emergency Care refer to the section titled Emergency Services.

N. Autism Spectrum Disorder Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Autism Spectrum Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(2) Coverage is provided for the treatment of Autism Spectrum Disorders, including behavioral therapies such as Applied Behavior Analysis (ABA). Benefits are limited to Health Care Services prescribed by your physician in accordance with a treatment plan. Coverage for Health Care Services will be provided as prescribed by your treating physician in accordance with the treatment plan.

(3) Any exclusion or limitation in this Contract in conflict with the coverage described in this section will not apply.

(4) Coverage for Autism Spectrum Disorders will not be subject to limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Contract.

O. Physician Home Visits and Office Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service a Health Care Service must be Medically Necessary.

(1) Covered Services include care provided by a physician, including employees of the physician such as an advanced practice nurse or physician assistant, in his/her office or your home. Refer to the sections titled Preventive Care, Maternity Care, Home Care Services, and Behavioral Health Care Services for services covered by this Contract. For Emergency Care refer to the Emergency Services section.

(2) Office visits for medical care and consultations to examine, diagnose, and treat a Sickness or injury performed in the physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a physician's office, no Copayment is required however Coinsurance will apply.

(3) Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

(4) Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

(5) Surgery and surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

(6) Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a physician or other professional Provider.

P. Preventive Care Services. Preventive Care Services include, Outpatient services and Office Services. Screenings and other Health Care Services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Covered Persons who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

(2) Preventive Care Services in this section shall meet requirements as determined by federal and state law.

(a) Health Care Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF. Covered Services include the screenings for following.

- Breast cancer.
- Cervical cancer.
- Colorectal cancer.
- High Blood Pressure.
- Type 2 Diabetes Mellitus.
- Cholesterol.
- Child and Adult Obesity.
- For Covered Persons age 15 – 65 and other ages at increased risk, Human Immunodeficiency Virus (HIV)
- Depression for adults
- Screening for alcohol misuse

(b) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(c) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Well Baby visits and care.
- Newborn screening for hearing
- Lead screening for children at risk for exposure
- Depression screening for adolescents

(d) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Women's contraceptives, sterilization procedures, and counseling. This includes generic drugs only, unless there is no generic equivalent, obtained from a Participating Pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms and intrauterine devices (IUDs) are also covered. When generic equivalents are available, prescription brand name contraceptives will not be covered under the Preventive Care benefit. Instead, prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the Prescription Drug Benefits section.
- Breastfeeding support, supplies, and counseling.
- Gestational diabetes screening.

(3) Covered Services also include the following services required by state law:

(a) Breast Cancer Screening. The following are Covered Services.

(a) If the female Covered Person is at least 35 years of age, one (1) baseline breast cancer screening mammography performed before she becomes 40 years of age.

(b) If the female Covered Person is less than 40 years of age and is high risk, one (1) breast cancer screening mammography performed every year. A woman is considered "high risk" if she meets at least one (1) of the following.

(A) Has a personal history of breast cancer.

(B) Has a personal history of breast disease proven benign by biopsy.

(C) Has a mother, sister, or daughter who has had breast cancer.

(D) Is at least 30 years of age and has not given birth.

(c) Any additional mammography views that are required for proper evaluation.

(d) Ultrasound services, if determined Medically Necessary by the physician treating the Covered Person.

(b) Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Service for a Covered Person under the age of fifty (50) if the Covered Person is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsymptomatic Covered Person, in accordance with the current American Cancer Society guidelines.

(c) Diagnostic Prostate Cancer Screening. If male Covered Person is at least 50 years of age, one (1) prostate specific antigen test annually is a Covered Service. If a male Covered Person is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test annually is a Covered Service.

Q. Surgical Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes the following.

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

(2) The surgical fee includes normal post-operative care.

(3) We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact us for more information.

(4) Covered Surgical Services include the following.

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

R. Reconstructive Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

(2) Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract.

(3) Covered Services are limited to the following.

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

(4) For a Covered Person who has undergone a mastectomy Covered Services include the following.

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

S. Sterilization.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

Sterilization is a Covered Service.

T. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

(2) Covered Services include removable appliances for repositioning and related surgery, medical care, and diagnostic services.

(3) Non-Covered Services include the following:

- Fixed or removable appliances that involve movement or repositioning of the teeth.
- Repair of teeth (fillings).
- Prosthetics (crowns, bridges, dentures).

U. Therapy Services.

Benefits are provided for therapy services that can be Rehabilitative or Habilitative. For purposes of this section and the Schedule of Benefits, the following definitions apply:

- Rehabilitation refers to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech therapy and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Physical therapy.

(a) Physical therapy includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve

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

(b) Non-Covered Services include the following.

- 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.

(3) Speech Therapy. Speech therapy for the correction of a speech impairment.

(4) Occupational Therapy. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

(a) Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

(b) Non-Covered Services include the following.

- Supplies (looms, ceramic tiles, leather, utensils).
- Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again.
- General exercises to promote overall fitness and flexibility.
- Therapy to improve motivation.
- Suction therapy for newborns (feeding machines).
- Soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial.
- Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

(5) Manipulation Therapy. Manipulation Therapy includes osteopathic/chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

(a) Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any limitation for Manipulation Therapy services as specified in the Schedule of Benefits.

(b) Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

(6) Other Therapy Services.

(a) Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

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

(c) Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage this Contract will not require you to receive dialysis treatment at a Participating Provider that is a dialysis facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Participating Dialysis Facility is more than 30 miles from your home, you may, upon our prior written consent, receive treatment at a Non-Participating Provider that is a dialysis facility nearest to your home as Covered Service.

(d) Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

(e) Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to:

- Introduction of dry or moist gases into the lungs.
- Nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication.
- Continuous positive airway pressure ventilation (CPAP).
- Continuous negative pressure ventilation (CNP).
- Chest percussion.
- Therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers.
- Broncho-pulmonary drainage.
- Breathing exercises.

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

V. Physical Medicine and Rehabilitation Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

(2) The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting. Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

(3) Non-Covered Services include the following.

- Admission to a Hospital mainly for physical therapy.
- Long term rehabilitation in an Inpatient setting.

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

W. Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Cost Sharing.

(2) "Covered Transplant Procedure" includes any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

(3) "Transplant Benefit Period" starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.

(4) Transplant services require Precertification.

(5) Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are a Covered Service as routine Diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

(6) Transportation and Lodging. This Contract will provide assistance with reasonable and necessary travel expenses as determined by us when you obtain Precertification and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when claims are filed.

(7) Non-Covered Services for transportation and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

X. Prescription Drug Benefits.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Pharmacy Benefits Manager (PBM).

(a) The Prescription Drug benefits are managed by our Pharmacy Benefits Manager or PBM. The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy, a Specialty Pharmacy, and provides clinical management services. The management and other services the PBM provides include, making recommendations to, and updating, the "covered Prescription Drug list" (the "covered Prescription Drug list" is referred to as the "Formulary"), managing a network of retail pharmacies, operating a mail service pharmacy, and operating a Specialty Pharmacy network.

(b) The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of Prescription Drug benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions or drug/pregnancy concerns. You may request a copy of the Formulary by calling the Customer Service telephone number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage.

(c) For certain Prescription Drugs, the prescribing Provider may be asked to provide additional information before the PBM and/or we can determine Medical Necessity. We may, in our sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer.

(d) Precertification may be required for certain Prescription Drugs (or the prescribed quantity of a particular Prescription Drug). At the time you fill a prescription, the Participating Pharmacy is informed of the Precertification requirement through the Participating Pharmacy's computer system. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee which is reviewed and adopted by us.

(e) For a list of the current Prescription Drugs requiring Precertification, please contact the Customer Service telephone number on the back of your Identification Card or go to our website at [insert url to formulary]. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage. Your Provider or Participating Pharmacy may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under this Contract.

(2) Therapeutic Substitution of Prescription Drugs. This is a voluntary program designed to inform Covered Persons and Providers about possible substitutes to certain Prescription Drugs. We, or the PBM, may contact you and your prescribing Provider to make you aware of substitution options. Therapeutic substitutes may also be initiated at the time the Prescription Drug is dispensed.

(a) Only you and your Provider can determine whether the therapeutic substitute is appropriate for you.

(b) For questions or issues involving therapeutic substitutes, call the Customer Service telephone number on the back of your Identification Card.

(c) The therapeutic substitutes list is subject to periodic review and amendment.

(3) Step Therapy. Step therapy protocol means that a Covered Person may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Covered Persons access high quality yet cost effective Prescription Drugs. If a Provider decides that the monitored medication is needed the Precertification process is applied.

(4) Participating Specialty Pharmacy. The PBM's Specialty Pharmacy is available to Covered Persons who use Specialty Drugs.

(a) "Specialty Drugs" are Prescription Legend Drugs that are one of the following:

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

(b) Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, subject to a day supply limit for retail and mail service, and the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

(c) Questions regarding Specialty Drugs can be directed to the Customer Service telephone number on the back of your Identification Card.

(d) You may obtain a list of the Participating Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your Identification Card, or review the lists on our website at [insert address].

(5) Covered Services include the following.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Self-administered contraceptives, including oral contraceptives, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the Preventive Care section, please see that section for more details.
- Selected drugs to eliminate or reduce dependence on, or addiction to tobacco and tobacco products.
- Injectables.
- Selected preventive medications are covered with no Copayment or Coinsurance if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations. These medications include the following: vitamin D supplementation, folic acid supplementation, aspirin and oral fluoride supplementation.

(6) In addition to the Exclusions set forth in Article 4, Non-Covered Services include the following.

- Prescription Drugs dispensed by any mail service program other than the PBM's mail service pharmacy, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.

- Off label use, except as otherwise prohibited by law or as approved by us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription.
- Drugs not approved by the FDA except as otherwise prohibited by law.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a physician. This does not apply to drugs used in conjunction with a Diagnostic Service, with chemotherapy performed in the office or drugs eligible for coverage under the Medical Supplies benefit.
- Any drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by this Contract, or which exceed any age limits established by us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility drugs.
- Human growth hormone for children born small for gestational age.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact us for additional information on these Prescription Legend Drugs.
- Refills of lost or stolen medications.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, unless otherwise required by law or approved by us. "Clinically equivalent" means drugs that, for the majority of persons, can be expected to produce similar therapeutic outcomes for a disease or condition.

(7) If you have questions regarding whether a particular Prescription Drug is covered and which Tier a Prescription Drugs fall into, please call the Customer Service telephone number on the back of your Identification Card, or visit our website at [website address].

(8) Each Prescription Drug may be subject to a Deductible, Coinsurance or Copayment. If the prescription includes more than one covered Prescription Drug, a separate Coinsurance or Copayment will apply to each covered Prescription Drug. Your Copayment will be the lesser of your scheduled Copayment or the Allowable Amount.

(9) The number of days' supply of a Prescription Drug which you may receive is limited. The days' supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days' supply allowed for under this Contract, you should ask your Pharmacist

to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

(10) Your Copayment or Coinsurance amount may vary based on whether the Prescription Drug has been classified by us as a first, second, third, fourth or fifth "Tier" Prescription Drug. The determination of Tiers is made by us based upon clinical information, and where appropriate the cost of the Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

(a) Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This Tier will contain low cost and preferred generic medications as well as selected preventive medications that are covered with no Coinsurance or Copayment if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations.

(b) Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This Tier will contain non-preferred generic medications.

(c) Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This Tier will contain preferred brand name medications.

(d) Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This Tier will contain non-preferred brand name medications.

(e) Tier 5 Prescription Drugs will have a higher/comparative Coinsurance or Copayment than those in Tier 4. This Tier will contain medications that are considered Specialty Drugs.

We have established a Pharmacy and Therapeutics Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Precertification criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives. The Pharmacy and Therapeutics Committee also determines, where appropriate, the cost of a Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one drug over another in our patient program, and, where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by

mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

(11) From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, generic, mail service, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Prescription Drugs or preferred products for a limited period of time.

(12) The amount of Benefits paid is based upon whether you receive the Covered Services from a Participating Pharmacy, including a Participating Specialty Pharmacy, a Non-Participating Pharmacy, or the PBM's mail service program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug.

(13) How you obtain your Benefits depends upon whether you go to a Participating or a Non-Participating Pharmacy.

(a) Participating Pharmacy – Present your written prescription from your physician and your Identification Card to the pharmacist at a Participating Pharmacy. The Participating Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment or Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge and you believe the Prescription Drug should be covered, ask your pharmacist for an itemized receipt and submit it to us for reimbursement consideration.

(b) Specialty Drugs - You or your Provider can order your Specialty Drugs directly from a Participating Specialty Pharmacy, simply call the Customer Service telephone number on the back of your Identification Card. Your Specialty Drug may need Precertification prior to dispensing. Upon approval, your Specialty Drug will be delivered to your physician's office/your specified delivery location based on the physician's order. A clinician will be available to answer any questions you may have in regard to the Specialty Drug and the instructions.

(c) Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy, including a Non-Participating Specialty Pharmacy. You must submit a claim for reimbursement consideration as set forth in Article 8 Section C.

(d) The Mail Service Program – Complete the order and patient profile form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have your physician fax the prescription to the mail service pharmacy. Your physician may also phone in the prescription to the mail service pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the mail service pharmacy when you request a prescription.

(14) Drug Exception Program. This is a program designed to allow Covered Persons to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. Please call the Customer Service number on the back of your Identification Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or are currently undergoing a course of treatment using a Prescription Drug that is not on the Formulary, you may request an expedited review of your request for a drug exception. In such circumstances, we will provide you or your Designated Representative with our decision within twenty-four (24) hours after we receive your request.

Y. Pediatric Vision Services. The following Health Care Services are Covered Services only for Covered Person through the age of nineteen (19). The Contract only provides Benefits for vision care that is listed in this section.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A complete pediatric eye exam. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together. The exam may include the following.

- Case History.
- Cover test.
- Ocular Motility.
- Neurological Integrity.
- External Exam.
- Internal Exam.
- Retinoscopy.
- Phorometry testing.
- Point refraction.
- Tonometry.
- Opthalmoscopic exam.
- Confrontation Visual Fields.
- Biomicroscopy.
- Color Vision Testing.
- Diagnosis/Prognosis.
- Recommendations.

(2) Eyeglass Lenses. Lens options include a choice of plastic or polycarbonate. Lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include up to 55 mm in single vision, bifocal, trifocal or lenticular.

(3) Frames. This Contract offers a selection of frames that are covered.

(4) Contact Lenses. Coverage includes the following.

(a) Contact Lens professional fitting fees.

(b) Elective Contact Lenses (elective contact lenses are contacts that are chosen for comfort or appearance).

(c) Non-Elective Contact Lenses are only provided for the following medical conditions.

- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when the patient's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

(d) Medically Necessary contact lenses are available in lieu of ophthalmic lenses and may be subject to Copayments, Coinsurance and limitations. The Provider determines a patient's qualifying criteria at examination and evaluation, and will obtain any necessary Precertification from us for these services.

(5) Low Vision Benefits

(a) Comprehensive Low Vision Exam.

(b) Optical/Non-optical aids.

(c) Supplemental testing.

(6) Non-Covered Services include services incurred for, or in connection with, any of the items below.

- Non-elective contact lenses for any Covered Person who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- For safety glasses and accompanying frames.
- For Inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Covered Person has reached the normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Contract.
- Cosmetic lenses or options.
- Blended lenses.

- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Vision services for Covered Persons over the age of nineteen (19) unless specifically stated in this Contract.

ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS

A. Non-Covered Services.

This Article 5 sets forth services that are excluded from coverage under this Contract and therefore are Non-Covered Services. Non-Covered Services are not covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

B. Exclusions. The following are Non-Covered Services:

(1) Services that we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.

(2) Services received from an individual or entity that is not a Provider.

(3) Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.

(4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

(5) Services provided as benefits by any governmental unit, unless otherwise required by law or regulation.

(6) Services for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

(7) Services for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

(8) Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

(9) Court ordered testing or care unless Medically Necessary.

(10) Services for which you have no legal obligation to pay in the absence of this or like coverage.

(11) Charges for consulting with Covered Persons by telephone, facsimile, electronic mail systems or other consultation or medical management service not involving

direct (face-to-face) care with the Covered Person except as otherwise described in this Contract.

(12) Surcharges for furnishing and/or receiving medical records and reports.

(13) Charges for doing research with Providers not directly responsible for your care.

(14) Charges that are not documented in Provider records.

(15) Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.

(16) Administrative or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

(18) Services prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

(19) Completion of claim forms or charges for medical records or reports unless otherwise required by law.

(20) Missed or canceled appointments.

(21) Mileage, lodging and meals costs, and other travel related expenses, except as authorized by us or specifically stated as a Covered Service in this Contract.

(22) Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.

(23) Services incurred prior to the Effective Date.

(24) Services incurred after the termination date of this coverage except as specified elsewhere in this Contract.

(25) For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Complications directly related to Cosmetic Services treatment or surgery, as determined by us, are not covered. This exclusion applies even if the original Cosmetic Services treatment or surgery was performed while the Covered Person was covered by another carrier/self-funded

plan prior to coverage under this Contract. "Directly related" means that the treatment or surgery occurred as a direct result of the Cosmetic Services treatment or surgery and would not have taken place in the absence of the Cosmetic Services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

(26) Custodial Care, convalescent care or rest cures.

(27) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

(28) Services provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

(29) Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

(30) Services or care provided or billed by a school, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(31) Wilderness camps.

(32) For routine foot care (including the cutting or removal of corns and calluses), Nail trimming, cutting or debriding, Hygienic and preventive maintenance foot care, including but not limited to 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.

(33) Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

(34) Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to the following.

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

(35) 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.

(36) Dental implants.

(37) Dental braces.

(38) Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following.

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer or cleft palate.

(39) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

(40) Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

(41) Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by us, are not covered. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(42) Marital counseling.

(43) Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

(44) Vision orthotic training.

(45) Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.

(46) Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

(47) Services to reverse voluntarily induced sterility.

(48) Diagnostic testing or treatment related to infertility.

(49) Personal hygiene, environmental control, or convenience items including but not limited to the following.

- Air conditioners, humidifiers, air purifiers.
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals.
- Charges for non-medical self-care except as otherwise stated.
- Purchase or rental of supplies for common household use, such as water purifiers.
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds.
- Infant helmets to treat positional plagiocephaly.
- Safety helmets for Covered Persons with neuromuscular diseases.
- Sports helmets.

(50) Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

(51) Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by us, or as otherwise described in this Contract.

(52) Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.

(53) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

(54) For self-help training and other forms of non-medical self-care, except as otherwise provided in this Contract.

(55) Examinations relating to research screenings.

(56) Stand-by charges of a Provider.

(57) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

(58) Services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

(59) Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Contract.

(60) Manipulation Therapy services rendered in the home as part of Home Care Services.

(61) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. This Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

(62) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

(63) Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

(64) Any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(65) Surgical treatment of gynecomastia.

(66) Treatment of hyperhidrosis (excessive sweating).

(67) Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by us through Precertification.

(68) Complications directly related to a service or treatment that is a Non-Covered Service under this Contract because it was determined by us to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

(69) Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

(70) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

(71) Treatment of telangiectatic dermal veins (spider veins) by any method.

(72) Reconstructive services except as specifically stated in this Contract or as required by law.

(73) Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

(74) For non-preventive medical nutritional therapy.

(75) Abortions that are not Therapeutic Abortions.

C. Experimental/Investigative Health Care Services Exclusion. We do not provide coverage for any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be Experimental/ Investigative.

(1) 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.

(a) 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 granted.

(b) Has been determined by the FDA to be contraindicated for the specific use.

(c) Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

(e) 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.

(2) Any Health Care Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by us. In determining whether a Health Care Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

(a) The scientific evidence is conclusory concerning the effect of the Health Care Service on health outcomes.

(b) The evidence demonstrates the Health Care Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects.

(c) The evidence demonstrates the Health Care Service has been shown to be as beneficial for the total population for whom the Health Care Service might be proposed as any established alternatives.

(d) The evidence demonstrates the Health Care Service has been shown to improve the net health outcomes of the total population for whom the Health Care Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(3) Off-Label Drug Treatment. Coverage for a drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

(a) The drug is recognized for treatment of the indication in at least one standard reference compendium.

(b) The drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have

been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the drug's use to be contraindicated or the drug has not been approved by the FDA for any indication.

(4) The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

(a) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.

(b) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.

(c) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Documents of an IRB or other similar body performing substantially the same function.

(e) Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(f) Medical records.

(g) The opinions of consulting Providers and other experts in the field.

ARTICLE 6. OBTAINING COVERED SERVICES

A. Participating Providers.

(1) Unless otherwise specifically provided in this Contract, in order to receive Benefits under this Contract, a Covered Person must receive Covered Services from a Participating Provider.

(2) The Covered Person is responsible for verifying that a Provider is a Participating Provider. A list of Participating Providers is available online at [insert website] or by calling us at [toll free number].

B. Non-Participating Providers. Health Care Services received from Non-Participating Providers are Non-Covered Services except for the following circumstances.

(1) Emergency Health Care Services.

(a) If we determine that the Health Care Services were not an Emergency, the Health Care Services are Non-Covered Services and you will be responsible for costs associated with the Health Care Services.

(b) Subsequent follow up care by a Non-Participating Provider after the condition is no longer an Emergency is a Non-Covered Service unless specifically authorized by us.

(c) If a Covered Person is hospitalized in a Non-Participating Hospital due to an Emergency, you or the Provider must notify us within 48 hours of the admission. A continued stay after the condition is stabilized and is no longer an Emergency requires our written authorization. We may elect to transfer the Covered Person to a Participating Hospital once it is medically appropriate to do so.

(2) Non-emergency Medically Necessary Health Care Services that cannot be provided by a Participating Provider and for which the Covered Person has obtained a Referral from his/her Primary Care Physician.

(3) Maternity services for a Covered Person who was in her second or third trimester of pregnancy as of her Effective Date as provided in Article 3 Section K.

(4) When our agreement with a Participating Provider terminates, upon your written request, [you] [the Covered Person] may continue to receive Covered Services from the Provider for the following time periods.

(a) Up to sixty (60) days.

(b) In the case of Covered Person who is pregnant and in the third trimester of pregnancy, you may continue to receive Covered Services through the term of the pregnancy.

(c) For a Covered Person who is hospitalized until the Covered Person is discharged from Inpatient status.

C. Primary Care Physician.

(1) You must designate a Primary Care Physician for each Covered Person. If you do not select a Primary Care Physician we will assign one.

(2) The Covered Person's Primary Care Physician will be responsible for coordinating Covered Services and making referrals to other Participating Providers. A Covered Person does not need a referral from his/her Primary Care Physician for obstetrical or gynecological treatment from a Participating Provider. A Covered Person may seek care directly from an obstetrician or gynecologist that is a Participating Provider. For all other Providers, the Covered Person must obtain a referral from his/her Primary Care Physician to obtain benefits for Covered Services under this Contract.

(3) You may change the selection of a Primary care Physician no more frequently than once each month. A Covered Person may change his/her Primary Care Physician by submitting a written request, online at [insert website address], or by contacting us at the number shown on your Identification Card. A change in Primary Care Physician selection will be effective no later than thirty (30) days from the date we receive a request.

ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES.

This Article 7 sets forth the procedures for requesting approvals for Covered Services from us as well as general Grievance procedures. In processing claims, we review requests for Precertification, Predetermination, and Post Service Clinical Claims Review to determine whether provided or proposed to be provided Health Care Services are Covered Services. Health Care Services must be Medically Necessary for Health Care Services to be considered Covered Services.

A. Covered Service Review Requests.

(1) Types of Covered Service Review Requests.

(a) Precertification – 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.

(b) Predetermination – An optional, voluntary prior or concurrent request for a benefit coverage determination for a Health Care Service. We will review [your] [this] Contract to determine if there is an Exclusion for the service or treatment requested. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service or treatment meets our definition of Medical Necessity, or if it is Experimental/Investigative as that term is defined in this Contract.

(c) Post Service Clinical Claims Review – A retrospective review (Post-Service) for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Precertification and did not undergo a Predetermination review. Post Service Clinical Claims Reviews are done for Health Care Services for which we have a related clinical coverage guideline and are typically initiated by us.

(2) Most Participating Providers know which Health Care Services require Precertification and will get Precertification or ask for Predetermination from us as needed. [Your] [The Covered Person's] Primary Care Physician and all other Participating Providers have received information from us on the procedures for requesting approvals for Covered Services and are responsible for meeting the requirements under such procedures. Generally, the Participating Provider ordering the service, treatment or admission will contact us to ask for Precertification or Predetermination reviews ("Requesting Provider"). We will work directly with [your] [the] Requesting Provider regarding such review requests; however, [your] [the Covered Person's] Designated Representative may act on [your] [the Covered Person's] behalf throughout the review process.

(3) We will utilize our clinical coverage guidelines, including internally developed guidelines, procedures, and preventative care clinical coverage guidelines, to help us determine whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions Identified

as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

(4) [You are] [The Covered Person is] entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact us at [toll free number].

B. Review Request Categories.

(1) Urgent Care – A request for Precertification or Predetermination that in the view of [your] [the] attending Provider, or any physician with knowledge of [your] [the Covered Person's] medical condition, could seriously jeopardize [your] [the Covered Person's] life or health or [your] [the Covered Person's] ability to regain maximum function, or would subject [you] [the Covered Person] to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Urgent Care Claim.

(2) Pre-Service – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

(3) Concurrent Care – A request for Precertification or Predetermination that is conducted during an ongoing course of treatment or admission. If we have approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by us of such course of treatment before the end of such period of time or number of treatments shall constitute a benefit determination adverse to [you][the Covered Person]. We will notify [you] [the Covered Person] sufficiently in advance of the reduction or termination to allow [you] [the Covered Person] to appeal and obtain a determination before the benefit is reduced or terminated.

(4) Post-Service – A request for approval that is made after the service, treatment or admission has occurred. Post-Service review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

C. Benefit Decision and Notice Requirements.

(1) We will resolve benefit review requests according to the timeframes listed in the table below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws.

Request Categories	**Timeframe Requirement for Benefit Decisions and Notification**
Pre-Service Claim	15 calendar days from receipt of request
Pre-Service Urgent Care Claim	72 hours from receipt of request

Concurrent Care Claim	15 calendar days from receipt of request
Concurrent Urgent Care Claim	24 hours from receipt of request
Post-Service Claim	20 business days from receipt of request

D. Timeframe Extensions for Benefit Decisions and Notifications.

(1) Post-Service and Pre-Service Claims. If we are unable to complete our review due to circumstances beyond our control, we will notify [you, your] [the Covered Person, the Covered Person's] Designated Representative, and the Requesting Provider in writing within:

(a) Fourteen (14) days after our receipt of a Pre-Service claim review request, and

(b) Nineteen (19) days after our receipt of a Post-Service claim review request.

The written notice will include the reason for the delay, a list of any applicable additional information that we need from [you] [the Covered Person] in order to complete our review and a revised timeframe for the resolution. If the reason for the delay is because [your] [the Covered Person's] review request lacked sufficient information to complete our review of [your] [the Covered Person's] request, [you, your] [the Covered Person, the Covered Person's] Designated Representative and Requesting Provider will have forty-five (45) days from receiving our notice of delay to provide the necessary information. We will notify [you, your] [the Covered Person, the Covered Person's] Designated Representative and the Requesting Provider of our decision within not more than ten (10) days after notifying [you, your] [the Covered Person, the Covered Person's] Designated Representative and Requesting Provider of the reason for our delay or of our receipt of the necessary information or of the end of the period afforded to [you] [the Covered Person] to supply the necessary information, as applicable. If we do not get the specific information we need or if the information is not complete by the timeframe provided to [you] [the Covered Person], we will make a decision based upon the information we have.

(2) Urgent Care Claims. If [you fail] [the Covered Person fails] to provide us with sufficient information to review [your] [the Covered Person's] Urgent Care Claim review request, we will notify [you] [the Covered Person] as soon as possible, but not later than twenty-four (24) hours after our receipt of the claim, of the specific information necessary to complete our review. [You] [The Covered Person] will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. We will notify [you, your] [the Covered Person, the Covered Person's] Designated Representative and Requesting Provider of our decision as soon as possible, but in no case later than forty-eight (48) hours of the earlier of the following:

(a) our receipt of the necessary information, or

(b) the end of the period afforded to [you] [the Covered Person] to supply the necessary information.

If we do not get the specific information we need or if the information is not complete by the timeframe provided to [you] [the Covered Person], we will make a decision based upon the information we have.

E. Denial of Experimental Treatment.

(1) If we deny coverage for a treatment, procedure, drug or device on the grounds that the treatment, procedure, drug or device is experimental, we will provide [you] [the Covered Person] with a written explanation that includes the following information:

(a) The basis for the denial.

(b) [Your] [The Covered Person's] right to Appeal our decision.

(c) Our telephone number that [you] [the Covered Person] may contact for assistance in initiating an Appeal of our decision.

(2) If [your] [the Covered Person's] health situation is life threatening or is an emergency, [you are] [the Covered Person is] entitled to a review of our decision to deny coverage on the grounds that the treatment, procedure, drug or device is experimental that takes not more than seventy-two (72) hours.

F. What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(1) Availability, delivery, appropriateness, or quality of health care services.

(2) Handling or payment of claims for health care services.

(3) Matters pertaining to the contractual relationship between you and us.

G. Who May File.

(1) You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

(2) If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

H. How a Grievance May Be Filed.

(1) You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, Toll Free Number and Fax]

(2) A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

I. No Retaliation. Neither [you nor your] [the Covered Person's] Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 7.

J. Grievance Procedure.

(1) Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

(2) Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

(3) Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

(4) Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

(5) Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

K. Appeals Procedure.

(1) Right to an Appeal.

(a) If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

(b) You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

(c) The Appeal may be expressed orally or in writing by contacting us at the address and phone number provided below.

[Address, Toll Free Number and Fax]

(d) We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

(2) Appeal Panel.

(a) We will appoint a panel of qualified individuals to resolve your Appeal (the "Appeal Panel"). The Appeal Panel will resolve your Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

(b) The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date and place during normal business hours for the Appeal Panel to meet to discuss your Appeal. You will be given seventy-two (72) hours advance notice of the date and time of the meeting.

(c) You or Your Designated Representative may:

(a) appear in person before the Appeal Panel; or

(b) communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

(d) You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

(e) To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

(f) The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

(g) If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:

(a) Has knowledge in the medical condition and Health Care Service;

(b) Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and

(c) Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with you or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.

(3) Appeal Decision and Notice of Decision.

(a) The Appeal Panel's decision regarding your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

(b) The Appeal Panel will resolve Appeals according to the timeframes listed in the table below.

Appeal Categories	**Timeframe Requirement for Appeal Decisions and Notification**
Appeal of a Pre-Service Claim Decision	30 calendar days from our receipt of the Appeal
Appeal of a Pre-Service Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Concurrent Care Claim Decision	15 calendar days from our receipt of the Appeal
Appeal of a Concurrent Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Post-Service Claim Decision	45 calendar days from our receipt of the Appeal

(c) We shall notify [you] [the Covered Person] or [your] [the Covered Person's] Designated Representative of our decision in writing regarding [your] [the] Appeal within five (5) business days after we complete our investigation.

(4) Expedited Review of Internal Appeals.

(a) An Expedited Review of an internal Appeal may be initiated orally, in writing or by other reasonable means available to [you, your] [the Covered Person, the Covered Person's] Designated Representative or [your] [the Covered Person's] Provider.

(b) Expedited Review is available only if [your] [the Covered Person's] attending Provider believes that, based upon [your] [the Covered Person's] medical condition, our standard internal Appeal procedure

could seriously jeopardize [your] [the Covered Person's] life or health or [your] [the Covered Person's] ability to regain maximum function, or could subject [you] [the Covered Person] to severe pain that cannot be adequately managed.

(c) Appeals of Urgent Care Claim decisions are referred directly to our Expedited Review procedure for investigation and resolution.

(d) We will complete our Expedited Review of [your] [the] Appeal as soon as possible given the medical exigencies but no later than within 72 hours after our receipt of [your] [the Covered Person] request for Appeal.

(e) We will communicate our decision regarding [your] [the] Appeal by telephone to [you, your] [the Covered Person, the Covered Person's] Designated Representative, and [your] [the Covered Person's] attending Provider. We will also provide written notice of our decision to [you, your] [the Covered Person, the Covered Person's] Designated Representative and [your] [the Covered Person's] attending Provider.

(f) An Expedited Review of Concurrent Urgent Care Claims and Pre-Service Urgent Care Claims may occur at the same time as an External Review (as described below).

L. External Review.

(1) [You] [The Covered Person] or [your] [the Covered Person's] Designated Representative may seek External Review if our decision regarding [your] [the Covered Person's] Appeal upheld a decision that was adverse to you regarding any of the following.

(a) A Medically Necessary service.

(b) A utilization review decision.

(c) A determination that a proposed service is Experimental/Investigational.

(d) A decision to rescind [your] [the Covered Person's] Contract.

If [your] [the Covered Person's] Appeal did not involve one of the above adverse decisions, [you are] [the Covered Person is] not entitled to an External Review.

(2) If [you have] [the Covered Person has] the right to an External Review under Medicare (42 U.S.C. 1395, et seq.) [you] [the Covered Person] may not request an External Review of our Appeals decision under the procedures outlined in this Contract.

(3) If [your] [the Covered Person's] situation qualifies, [you] [the Covered Person] or [your] [the Covered Person's] Designated Representative must file a written request for an External Review with us within 120 days after [you receive] [the Covered Person receives] notice of our internal response to the Appeal.

(4) Independent Review Organization (IRO).

(a) If an External Review is requested, we will forward all information related to [your] [the Covered Person's] External Review to an IRO selected from the list of IROs that are certified by the Indiana Department of Insurance.

(b) The IRO will make a determination to uphold or reverse our Appeal decision within seventy-two (72) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within fifteen (15) business days if the condition does not involve an Urgent Care Claim.

(c) The IRO will notify [you and your] [the Covered Person and the Covered Person's] Designated Representative of its decision within twenty-four (24) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within seventy-two (72) hours if the review does not involve an Urgent Care Claim.

(d) If the IRO decision reverses our Appeals decision, we will notify [you, your] [the Covered Person, the Covered Person's] Designated Representative or Provider in writing of the steps we will take to comply with the IRO's decision.

M. Important Contact Information and Notice to Covered Persons.

(1) Questions regarding [your] [the Covered Person's] coverage should be directed to: Indiana University Health Plans; [toll free number]

(2) If [you] [the Covered Person] (a) [need] [needs] the assistance of the governmental agency that regulates insurance; or (b) [have] [has] a complaint [you have] [the Covered Person has] been unable to resolve with us [you] [the Covered Person] may contact the Department of Insurance by mail, telephone or email:

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

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

Complaints can also be filed electronically at www.in.gov/idoi.

(3) The review procedures described in this Article 7 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

ARTICLE 8. PAYMENT FOR COVERED SERVICES

A. How to Obtain Benefits.

(1) Whenever [you receive] [the Covered Person receives] Health Care Services, [you] [the Covered Person] must provide the Provider with a copy of [your] [the Covered Person's] Identification Card.

(2) When [you receive] [the Covered Person receives] Covered Services from a Participating Provider you are not required to file a claim. Since no claim filing is required, you are not required to follow the procedures outlined in Section C of this Article 8.

B. Who Receives Payment Under This Contract.

(1) We pay Benefits for [your] [the Covered Person's] Covered Services directly to a Participating Provider.

(2) [If you receive] [If the Covered Person receives] Covered Services from a Non-Participating Provider as provided in Article 6 Section B, we will pay Benefits to the Non-Participating Provider, unless you agreed to make payment to the Non-Participating Provider and are entitled to reimbursement for such payment.

C. Payment for Covered Services received from Non-Participating Providers.

(1) Time to File Claims. For Covered Services received from a Non-Participating Provider, written notice of a claim must be given to us, by you or the Non-Participating Provider, within thirty (30) days of the date the Covered Services began. Failure to furnish the claim within thirty (30) days will not invalidate or reduce any claim if submission within thirty (30) days was not reasonably possible, so long as the claim is submitted within a reasonable time.

(2) Claim Forms. We shall provide forms to you for filing Proof of Loss within fifteen (15) days of notice of any claim. If you do not receive the forms within fifteen (15) days, written notice of services rendered may be submitted to us without the claim form. Claim forms are available on our website at [website address].

(3) Proof of Loss. Proof of loss under this Contract must be furnished to us within ninety (90) days after the loss. Failure to furnish the claim within ninety (90) days will not invalidate or reduce any claim if submission within ninety (90) days after the loss was not reasonably possible, so long as the claim is submitted within one (1) year after the time required under this Contract unless you were legally incapacitated.

(4) Address. All correspondence regarding claims should be sent to us at:

Indiana University Health Plans
[Address]
[City/state/zip]
[Fax]

(5) Amount of Payment. Payment for Health Care Services received from a Non-Participating Provider will be the lesser of the following amounts.

(a) The usual, customary and reasonable charge for the Health Care Service;

(b) An amount agreed upon by us and the Non-Participating Provider.

D. Clean Claims.

(1) A clean claim is a claim submitted by a Provider for payment that has no defect. We shall pay or deny each clean claim as follows.

(a) If the claim is filed electronically, within thirty (30) days after the date we receive the claim.

(b) If the claim is filed on paper, within forty-five (45) days after the date we receive the claim.

(2) If we fail to pay or deny a clean claim in the time frames set forth above and subsequently pay the claim, we will pay the Provider that submitted the claim allowable interest in accordance with Indiana Code § 27-8-5.7-6.

ARTICLE 9. COORDINATION OF BENEFITS

This Article applies only if you also have other health benefits coverage with another Plan. The Definitions contained in this Article apply throughout this Article 9 but do not apply to the rest of the Contract.

A. When you have other health benefits. In the event that you are covered by two health insurance contracts, plans or policies ("Plans") providing similar benefits and you receive a Health Care Service that would be covered by both Plans, we will coordinate benefit payments with any payment made under the other Plan. One company will pay its full benefit as the Primary Plan. The other company will pay Secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments.

B. Definitions.

(1) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the Plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(2) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

(3) "Closed Panel Plan" means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in the case of emergency or referral by a panel Covered Person.

(4) "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(5) "Plan" means any of the following that provides benefits or services for medical treatment:

(a) Any group or blanket insurance contract, plan or contract, except that blanket school accident coverage or such coverage offered to

substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or contract.

(b) Any self-insured or noninsured Plan or any other Plan arranged through an employer, trustee, union, employer organization or employee benefit organization.

(c) Any coverage under governmental programs or any coverage required to be provided by any statute. However, Medicaid and any Plan whose benefits are, by law, excess to those of any private insurance plan or other nongovernmental plan shall not be considered health insurance policies.

(d) Group or nongroup coverage through Closed Panel Plans or group type contracts.

(e) Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional "fault" type contracts.

(6) "Primary" or "Primary Plan" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If the Plan is Primary to another Plan, the Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(7) "Secondary" or "Secondary Plan" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If the Plan is Secondary to another Plan, the Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

C. Rules To Determine Payment. When two or more Plans pay benefits, the rules for determining the order of payments are as follows:

(1) The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

(2) If the other Plan does not have a provision similar to this one, then it will be primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(3) A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. Order of Determination of Benefits Rules. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent is Primary, for example as an employee, subscriber or retiree is

primary and the Plan that covers the person as a Dependent is Secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent; then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, subscriber or retiree is Secondary and the other Plan is Primary.

(2) Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods commencing after the Plan is given notice of the court decree.

(d) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(a) The Plan of the Custodial Parent.

(b) The Plan of the spouse of the Custodial Parent.

(c) The Plan of the non-Custodial Parent.

(d) The Plan of the spouse of the non-Custodial Parent.

(3) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is Primary. The same would hold true is a person is a Dependent of a person covered as a retiree or an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined Section (C)(1) of this Article 9.

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, subscriber or retiree (or as that person's Dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, subscriber or retiree longer is Primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid if it had been Primary.

E. Payment of the Benefit When This Plan is Secondary.

(1) When this Plan is Secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other Plan and this Plan do not exceed your expenses for an item of service. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by the Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

(a) Determine its obligation to pay or provide benefits under its Plan;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

(2) If there is a benefit reserve, the Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

(3) If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, Coordination of Benefits shall not apply between that Plan and other Closed Panel Plans.

F. Payments to Others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid.

G. Our Right to Recover Overpayment. In some cases, we may have made payment even though you had coverage under another Plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the

payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other Plan. You agree to sign any document that we deem necessary to help us recover any overpayment.

ARTICLE 10. TERMINATION OF COVERAGE

A. [**Guaranteed Renewable.** As long as [you continue] [a Covered Person continues] to be a Qualified Individual and this Contract continues to be a Qualified Health Plan, you may renew this Contract at your option without regard to the health status of you or any Covered Person.]

[Guaranteed Renewable. Coverage under this Contract is guaranteed renewable at the discretion of the Subscriber, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, as described in this Article 10. [You] [The Subscriber] may renew this Contract at [your] [the Subscriber's] option without regard to the health status of you or any Covered Person. You may renew this Contract by payment of the renewal premium by the end of the Grace Period of the premium due date, provided the following requirements are satisfied:

(1) Eligibility criteria outlined in Article 2 continues to be met.

(2) There are no fraudulent or intentional misrepresentations on the application or under the terms of this Contract.

(3) Coverage has not been terminated by us under the terms of this Contract.]

B. **Termination.** We may terminate this Contract or coverage of a Covered Person for the following reasons.

(1) [You are] [The Covered Person is] no longer eligible for coverage [through the Indiana Marketplace].

(2) A Covered Person is no longer eligible under [the rules of the Indiana Marketplace or] the terms of this Contract.

(3) You do not pay premium and the applicable Grace Period has been exhausted.

(4) We receive a request from you to terminate the Contract.

(5) You [commit] [or a Covered Person commits] an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact.

(6) [You change] [A Covered Person changes] coverage to another [Qualified Health Plan] [health plan] during the [Indiana Marketplace] Open Enrollment Period or a Special Enrollment Period.

(7) [The Contract is no longer a Qualified Health Plan or we are decertified by the Indiana Marketplace.]

(8) You no longer reside in our Service Area.

(9) We discontinue a particular product provided that we provide you with written notice at least ninety (90) days before the date the product will be discontinued, we offer you the option to purchase any other individual contract we currently offer, and we act uniformly without regard to any health status-related factor.

(10) We discontinue all contracts in the individual market in Indiana provided that we provide you and the Indiana Department of Insurance with written notice at least 180 days before the date of the discontinuance, we discontinue and do not renew all contracts in the individual market in the State of Indiana, and we act uniformly without regard to any health status-related factor.

(11) We may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with the laws of the State of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

C. Effective Date of Termination. [Termination of this Contract automatically terminates all coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if [your] [this] Contract is in effect at the time such services are provided.]

(1) If you terminate this Contract or coverage for a Covered Person, the last day of coverage [will be on the last day of the billing period for which premium has been paid. A request for termination must be received by us in writing] [is:

(a) The termination date specified by you, if reasonable notice is provided;

(b) If you do not provide reasonable notice, fourteen (14) days after the termination is requested, or

(c) If you do not provide reasonable notice and request a termination date in less than fourteen (14) days, on a date determined by us if we are able to implement termination in fewer than fourteen (14) days.]

(2) [If newly eligible for Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.]

(3) [If [you] [all Covered Persons] are no longer eligible for coverage through the Indiana Marketplace, the last day of coverage is the last day of the month following the date notice is sent to us by the Indiana Marketplace, unless you request an earlier termination effective date.] [If you move outside of the Service Area, the last day of coverage for you and all of your Dependents will be at the end of the billing period that contains the date you no longer resided in the Service Area.]

(4) [If a Covered Person is no longer eligible for coverage under the rules of the Indiana Marketplace or the terms of this Contact, the last day of coverage is the last day of the month following the date the Covered Person loses eligibility.] [If a Dependent no longer meets the definition of Dependent, the last day of coverage for the Dependent will be on the last day of the billing period in which we received notice of the Dependents loss of eligibility.]

(5) In the case of a termination for non-payment of premium and the applicable Grace Period has been exhausted, the last day of coverage [for all Covered

Persons] will [be either the last day of the first month of the 3-month Grace Period or] the last day for which premium was paid.

(6) [In the case of a termination due to a change to another Qualified Health Plan, the last day of coverage is the day before the effective date of coverage in his or her new Qualified Health Plan.]

(7) [The day following a Covered Person's death. When a Subscriber dies, the surviving spouse, if covered under the Contract, may receive an individual contract. The surviving spouse should contact [the Indiana Marketplace] [us] to identify the process for enrollment.]

D. Notice of Termination.

(1) We shall provide you with written notice of our intent to terminate or not renew this Contract at least sixty (60) days prior to the effective date of the termination. This notice will identify the date upon which your coverage will terminate.

(2) Our notice to the Subscriber shall be deemed as notice to all Covered Persons and is sufficient if mailed to the Subscriber's address as it appears in our records.

(3) Termination of this Contract shall not prejudice any claim for Covered Services rendered before the effective date of the termination.

E. Continuation of Coverage.

(1) If we terminate this Contract, except for a termination due to our receivership, and a Covered Person is hospitalized for a medical or surgical condition on the effective date of the termination, coverage will continue for Inpatient Covered Services. Benefits shall end on the earliest of the following dates.

(a) The date the Covered Person is discharged from the Hospital.

(b) The date the Covered Person is covered under other health coverage if that coverage covers the Inpatient Hospital services.

(c) Sixty (60) days after the date this Contract ends.

(d) The last day the required premium has been paid if the Grace Period expires and the Subscriber has not made the required payment.

(e) The date the you terminate coverage.

(2) If this Contract terminates due to our receivership, coverage will continue for the following time period:

(a) The duration of the contract period for which premiums have been paid.

(b) If a Covered Person is hospitalized on the date of our receivership for the longer of the following time periods.

(A) The period ending when the Covered Person is discharged from the Inpatient hospitalization.

(B) The duration of the contract period for which premiums have been paid.

F. Rescission. If within two (2) years after the Effective Date of this Contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that [you] [the Subscriber] or a Covered Person did not disclose on [your] [the] application, we may rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding your newly born children within 31 days of birth), we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that [you] [the Subscriber] or a Covered Person did not disclose on the application, we may rescind coverage for the additional Dependent as of his or her original Effective Date. Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by [the Subscriber or] a Covered Person may result in termination or rescission of coverage. [You are] [The Subscriber is] responsible to pay us for the cost of previously received services based on the Allowed Amount for such services, less any Copayments/Coinsurance paid or Premium paid for such services.

This Contract may also be terminated if [you] [the Subscriber or a Covered Person] knowingly [participate] [participates] in or permit fraud of deception by any Provider, vendor or any other person associated with this Contract. Termination for any act, practice or omission that constituted fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give [you] [the Subscriber] at least thirty (30) days written notice prior to the rescission of this Contract.

G. Reinstatement. If [your] [this] Contract was terminated for non-payment of premium, you may request reinstatement of the Contract from [the Indiana Marketplace] [us] within 30 days of the effective date of the termination. You must remit all premium that was due for the coverage upon reinstatement. Upon [notice from the Indiana Marketplace and] receipt of the outstanding premium, we will reinstate coverage as of the effective date of the termination.

H. [**Certification of Prior Creditable Coverage If Required by Law.** If [your] [this] coverage is terminated, [you and your Dependents] [all Covered Persons] will receive certification from us showing that [you] [they] were covered under this Contract. [You] [A Covered Person] may need this certification document in order to purchase[, for yourself and/or your family,] other health coverage. Certifications may be requested within twenty-four (24) months of losing coverage.

[You] [A Covered Person] may also request certification be provided to [you] [he or she] at any other time, even if [you have] [he or she has] not lost your coverage under this Contract. If [you have] [a Covered Person has] any other questions regarding certification of creditable coverage, contact the Customer Service telephone number on the back of your Identification Card.]

ARTICLE 11. GENERAL PROVISIONS

A. **Entire Contract.** This Contract, the Schedule of Benefits, and any application, rider or amendment(s) make up the entire agreement between you and us as of the Effective Date and supersede all other agreements. All statements made by you shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce coverage under this Contract or be used in defense of a legal action unless it is contained in the application.

B. **No Assignment.** The benefits provided under this Contract are for [your and your enrolled Dependents'] [the] personal benefit [of all Covered Persons]. You may not assign any of [your] [these] rights to coverage. Any attempt by you to assign this Contract to any third party is void. Provided, however, that subject to our right to disapprove, you may assign your right to reimbursement for Covered Services to the Provider who provided such Covered Services.

C. **Notice.** Any notice that we give to you under this Contract will be mailed to your address as it appears on our records. Our notice to the Subscriber is deemed notice to all [enrolled Dependents]. Notice is deemed delivered three (3) calendar days after its deposit in the United State Mail with first class postage prepaid unless otherwise stated in this Contract. If you have to give us any notice, it should be mailed to:

Indiana University Health Plans, Inc.
950 North Meridian Street, Suite 200
Indianapolis, Indiana 46204

D. **Relationship Between Parties.** The relationships between us and Participating Providers are *solely* contractual relationships between a payor and independent contractors. Non-Participating Providers have no contractual relationship with us, nor are they our independent contractors. Providers are not our agents or employees. We and our employees are not employees or agents of Providers. The relationship between a Provider and any Covered Person is that of Provider and patient. The Provider is *solely* responsible for the services provided to any Covered Person.

E. **Disagreement with Recommended Treatment.** Each Covered Person enrolls in this Contract with the understanding that the Provider is responsible for determining the treatment appropriate for their care. [You] [The Covered Person] may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate Health Care Services in a manner compatible with [your] [the Covered Person's] wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice. [If you refuse] [If the Covered Person refuses] to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, [you] [the Covered Person] will be so advised. In such case, the Provider and we, as applicable, may determine that neither this Contract nor the Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of this Contract for the condition under treatment or any complications thereof.

F. **Your Medical Records.** As a condition precedent to the approval of claims hereunder, each Covered Person authorizes and directs any Provider that furnishes benefits hereunder to make available to us information relating to all Health Care Services, copies thereof and other records as needed by us for purposes of administering this Contract. In every case we will hold such information and records as confidential in accordance with state and federal confidentiality requirements.

G. **Second Opinion Policy.** A second opinion may be required at our discretion prior to the scheduling of certain Covered Services. We will advise you if a proposed Covered Service is subject to the second opinion policy. If so, you must consult with a second Participating Provider prior to the scheduling of the service. You must (a) contact us to obtain a list of Participating Providers who are authorized to render a second opinion, and (b) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider. You must obtain the second opinion within thirty-one (31) days of the first opinion or as soon thereafter as is reasonably possible. Second opinions we have arranged as described above are provided at no cost to you. A second opinion may also be obtained at the request of a Covered Person, subject to separate benefit restrictions and/or Copayments or Coinsurance described in this Contract.

H. **Who May Change This Contract.** This Contract may not be modified, amended or changed, except in writing, and signed by one of our officers. No employee, agent or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage or the conditions of eligibility, enrollment or participation unless in writing and signed by one of our officers. We are not bound by any verbal statements. We will provide [you] [the Subscriber] with written notice of any material modification to this Contract not later than sixty (60) days prior to the date on which such material modification will become effective.

I. **Renewal Date.** The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date for the term set forth in the Contract unless otherwise terminated by us as permitted by the Contract or by you upon thirty (30) days' prior written notice.

J. **Identification Cards.** Identification Cards are issued by us for identification only. Possession of any Identification Card confers no right to services or benefits under this Contract. To be entitled to such services or benefits the Covered Person's premiums must be paid in full at the time the Health Care Services are sought to be received. Coverage under this Contract may be terminated by us if the Covered Person allows another person to wrongfully use the Identification Cards.

K. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Contract. An example of the use of the standards is to determine whether care was Medically Necessary. These standards will not be contrary to the descriptions in this Contract. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Contract.

L. **Non-Discrimination.** In compliance with state and federal law, we shall not discriminate on the basis of age; gender; color; race; disability; marital status; sexual preference; religious affiliation; or public assistance status. We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care. We shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew Coverage, (b) cancel coverage, (c) limit Benefits, or (d) charge a different premium. We shall not discriminate against victims of abuse in compliance with Indiana Code Sec. 27-8-24.3-1.

M. **Incontestability.** The validity of the Contract may not be contested after two (2) years, except for nonpayment of premiums or if the disputed statement is in a written instrument signed by the Subscriber. The ineligibility of [the Subscriber or] a Dependent under the Contract may be disputed at any time.

N. **Limitation of Action.** Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Contract and within three (3) years from the date the Health Care Services were received.

O. **Examination of Covered Persons.** We may reasonably require that [you] [a Covered Person] be examined if a question or dispute about the provision of or payment for Covered Services arises. The exam will be performed by a Participating Provider acceptable to us. We will pay for the exam.

P. **Right of Recovery.** If we pay for Health Care Services that, according to the terms of the Contract, should not have been paid, we reserve the right to recover such amounts from whom they have been paid (including the Covered Person or Provider) or any other appropriate party.

Q. **Contract is not a Medicare supplement policy.** Any Covered Services that are covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled. The benefits under this Contract for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be Primary. Where Medicare is Primary, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

R. **Contract is Not Worker's Compensation Insurance.** The coverage provided under this Contract does not replace, supplement or provide a substitute for benefits to which a Covered Person is entitled under worker's compensation, occupational disease, and similar laws. The Contract does not cover Health Care Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's

compensation, occupational disease and similar laws, even when the circumstances below are present.

(1) If the Covered Person's employer is not properly insured or self-insured under such laws.

(2) When a Covered Person refuses to use his or her employer's designated Provider.

(3) When a Covered Person has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

A Covered Person must contact his employer or its worker's compensation or occupational disease insurer for the provision or payment of such Health Care Services.

S. General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within our control we will pay benefits for Covered Services as provided in this Contract to the extent that facilities and personnel are then available, and we shall have no liability or obligation for delay or failure to provide Covered Services due to lack of available facilities or personnel.

T. Typographical or Administrative Error. Typographical or administrative errors shall not deprive a Covered Person of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

U. Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on the Effective Date shall apply. Any Contract provision which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

V. Governing Law. This Contract will be subject to the laws of the state of Indiana.

W. Severability. In the event that any provision in the Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

[Schedule of Benefits]

[INSERT LOGO]

Individual/Family/Child-Only Contract Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Indiana University Health Plans, premium payment is required before the requested effective date. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call [1 800-XXX-XXXX]. If you have questions about a previously submitted application, please call [1 800-XXX-XXXX].

DISCLAIMER: The Affordable Care Act includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments of Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. **Please be advised that this Policy does not qualify for these affordability programs because it is not issued through the Indiana Marketplace.**

Section A – Coverage Information

Coverage Type (select one):

☐ Individual/Family ☐ Child-Only

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No. _____

Open Enrollment:

During the annual Open Enrollment period, you may apply for coverage, or change plans. The earliest Effective Date for the Initial Open Enrollment is [January 1, 2015]. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if Indiana University Health Plans, Inc. receives the application and initial premium payment between the 1st and 15th of the month. If Indiana University Health Plans, Inc. received the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st).

Applications must be received during the Open Enrollment period. An applicant may enroll outside of the Open Enrollment period only if he/she experiences a Special Enrollment triggering event provided below. Notice of a triggering event must be received by Indiana University Health Plans, Inc. within [60] days of the triggering event.

Special Enrollment Triggering Events:

Please check the triggering event:

☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;

☐ Loss of Minimum Essential Coverage due to dissolution of marriage;

☐ Marriage, birth, adoption or placement for adoption or appointment of guardianship;

☐ Violation of a Qualified Health Plan of a material contract provision;

☐ Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and result of an error, misrepresentation, or inaction of the Indiana Marketplace or the US Department of Health and Human Services;

☐ Newly ineligible for advance payments of premium tax credits or cost-sharing reductions.

☐ Relocation to a new service area;

☐ Determination that enrollment or non-enrollment in a Qualified Health Plan or an incorrect determination of ineligibility of advance payments of premium tax credits or cost-sharing reductions was the result of misconduct by a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities.

Please provide the date of the triggering event: _____

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)			
City	**State**	**ZIP**	**County**

Billing Address (street and P.O. Box if different from above)		
City	**State**	**ZIP**

Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth / /

Primary Phone Number ( )	Secondary Phone Number ( )	E-mail*

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this application.*

Last Name	First Name	MI	Relationship ☐ Spouse

Social Security Number*	Sex ☐ M ☐ F	Date of Birth / /

Section C – Spouse to be Covered Information (N/A if applying for Child-Only coverage)

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this application.*

Section D – Child Dependents to be Covered Information
(All fields must be completed. Attach a separate sheet if necessary).

Dependent information must be completed for all child dependents (if any) to be covered under this policy.

For family coverage, an eligible child dependent includes your child or your spouse's child, including any of the following until the child attains the age of 26: your natural child, stepchild, legally adopted child, child placed for the purpose of adoption, or child placed under legal guardianship or legal custody.

For child-only coverage, an eligible child dependent includes your child or your spouse's child, including any of the following until the child attains the age of 21: your natural child, stepchild, legally adopted child, child placed for the purpose of adoption, or child placed under legal guardianship or legal custody.

(Please list all dependents beginning with the eldest.)

Last Name	**First Name**	**MI**	**Sex**	**Date of Birth mm/dd/yyyy**	**Social Security Number***	**Relationship to Applicant**
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other: _____
			M F ☐ ☐			☐ Child ☐ Other: _____
			M F ☐ ☐			☐ Child ☐ Other: _____
			M F ☐ ☐			☐ Child ☐ Other: _____

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this application.*

Are all applicants listed on this application residents of Indiana? ☐ Yes ☐ No

If **YES**, please list the county of residence for each applicant:_____

_____

If **NO**, please list each applicant that is not a resident of Indiana:_____

_____

Has any applicant used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No

If **YES**, please list each applicant that has used tobacco products 4 or more times per week, on average, in the last 6 months:_____

_____

Section E – Medical Coverage
[[Plan Name] [and] [Deductible/Coinsurance Options]]

Select ONE Plan.

[☐ IU Health Plans Bronze Value]

[☐ IU Health Plans Bronze Enhanced]

[☐ IU Health Plans Silver Value]

[☐ IU Health Plans Silver Enhanced]

[☐ IU Health Plans Silver Value 87]

[☐ IU Health Plans Silver Enhanced 87]

[☐ IU Health Plans Silver Value 73]

[☐ IU Health Plans Silver Enhanced 73]

[☐ IU Health Plans Silver Value 94]

[☐ IU Health Plans Silver Enhanced 94]

[☐ **IU Health Plans Gold Value]**

HSA Plans

[☐ IU Health Bronze HSA]

[☐ IU Health Plans Silver HSA]

[☐ IU Health Plans Silver HAS 87]

[☐ IU Health Plans Silver HSA 73]

[☐ IU Health Plans Silver HSA 94]

Health Savings Account Election:

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Indiana University Health Plans, Inc.'s banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Indiana University Health Plans, Inc.'s banking partner.

Section F – Pediatric Dental Coverage Certification

Child dependents age 19 and under are required to enroll in pediatric dental coverage that is certified by the Indiana Marketplace. Indiana University Health Plans, Inc. does not offer this mandated pediatric dental coverage.

☐ **YES**, I will enroll my child dependent(s) age 19 and under in a standalone dental plan that meets the mandated pediatric dental coverage requirement.

☐ **NO,** I will not enroll my child dependent(s) age 19 and under in a standalone dental plan that meets the mandated pediatric dental coverage requirement.

Section G – Other Health Coverage For Purposes of Coordination of Benefits Under the Policy

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, please list all applicants that are currently eligible for Medicare: _____

_____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No

If **YES**, please list all applicants current receiving such benefits and the reason they are receiving such benefits:

_____

_____

_____

Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____

Do you, or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If YES, please provide the following information:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for Indiana University Health Plans, Inc. coverage? ☐ Yes ☐ No
If **YES**, what is the cancellation date? _____

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although Indiana University Health Plans, Inc.'s requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Indiana University Health Plans, Inc., does not mean that coverage has been approved. I may not assign any payment under my Indiana University Health Plans, Inc. program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Indiana University Health Plans, Inc. reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify Indiana University Health Plans, Inc. of any change that would make me or any dependent ineligible for coverage.
- [I understand Indiana University Health Plans, Inc. may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Indiana University Health Plans, Inc. automatic debit process and will only occur each time I send a check to Indiana University Health Plans, Inc.. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.]
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Indiana University Health Plans, Inc. and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- ☐ By checking this box, I authorize and expressly consent that Indiana University Health Plans, Inc. and its affiliated companies may send e-mail communications instead of sending communications by mail, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting Indiana University Health Plans, Inc. customer service or online at [INSERT WEBSITE].
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Indiana University Health Plans, Inc. in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

REMAINDER OF PAGE LEFT BLANK

SIGNATURE PAGES FOLLOW

I give this authorization for and on behalf of any eligible dependents and myself if covered by Indiana University Health Plans, Inc.. I am acting as their agent and representative.

This application shall be altered solely by the applicant or with his or her written consent.

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your Indiana University Health Plans, Inc. appointed agent/broker:

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature **X**				Date
Agent/Broker Name (please print)		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.		
Agent/Broker ID/TIN	Agency ID/Parent TIN	City	State	ZIP
Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail		

Authorization for Use of Protected Health Information

By signing below: I authorize Indiana University Health Plans, Inc., or an agent/broker, subsidiary or affiliate that has a business associate contract with Indiana University Health Plans, Inc., to obtain any medical records or other health history information concerning me and any family member listed on my application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations.

This authorization is subject to revocation at any time by written notice to Indiana University Health Plans, Inc. except to the extent that Indiana University Health Plans, Inc. has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

Unless previously revoked, this authorization is valid for 24 months from the date of signature.

Printed name of Applicant/Member **X**	Signature of Applicant/Member or his/her Legal Representative **X**	Date
Printed name of Spouse or Dependent Child* age 18 or over listed on this application **X**	Signature of Spouse or Dependent Child* or his/her Legal Representative **X**	Date
Printed name of Dependent Child* age 18 or over listed on this application **X**	Signature of Dependent Child* or his/her Legal Representative **X**	Date

**If listed on your application or change form, your spouse and each dependent child age 18 or over must sign above.*
If a legal representative signs on behalf of the applicant or spouse, a copy of the legal representative's authority must be attached to the application.
A photocopy of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.

IU Health Plans Bronze HSA

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$4,500 per Plan Year
Per Family	$9,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,350 per Plan Year
Per Family	$12,700 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	20% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Dental Services for Accidental Injury	20% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	20% Coinsurance after Deductible
Radiology Services	20% Coinsurance after Deductible
X-ray Services	20% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 20% Coinsurance after Deductible
Urgent Care Center Services	20% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	20% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	20% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	20% Coinsurance after Deductible
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	20% Coinsurance after Deductible
Specialty Physician	20% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	20% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	20% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$10 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$25 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$30 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$75 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Tier 5 (Specialty)	40% Coinsurance after Deductible
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Bronze Value

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$6,000 per Plan Year
Per Family	$12,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,350 per Plan Year
Per Family	$12,700 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	25% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	25% Coinsurance after Deductible
Inpatient Services	$1,500 Copayment per admission after Deductible and then 25% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	25% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$1,500 Copayment per admission after Deductible and then 25% Coinsurance after Deductible
Dental Services for Accidental Injury	25% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	25% Coinsurance after Deductible
Radiology Services	25% Coinsurance after Deductible
X-ray Services	25% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$350 Copayment per visit after Deductible and then 25% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	25% Coinsurance after Deductible
Hospice Services	25% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$1,500 Copayment per admission after Deductible and then 25% Coinsurance after Deductible
Inpatient Physician and Surgical Services	25% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	25% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	25% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$40 Copayment per visit
Delivery and Inpatient Services	$1,500 Copayment per admission after Deductible and then 25% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	25% Coinsurance after Deductible
Durable Medical Equipment	25% Coinsurance after Deductible
Prosthetics	25% Coinsurance after Deductible
Orthotic Devices	25% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	25% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	25% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$40 Copayment per visit
Specialty Physician	25% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	25% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	25% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	25% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	25% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	25% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$10 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$25 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$30 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$75 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Bronze Enhanced

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$5,000 per Plan Year
Per Family	$10,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,350 per Plan Year
Per Family	$12,700 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	40% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	40% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 40% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 40% Coinsurance after Deductible
Dental Services for Accidental Injury	40% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	40% Coinsurance after Deductible
Radiology Services	40% Coinsurance after Deductible
X-ray Services	40% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$275 Copayment per visit after Deductible and then 40% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit before Deductible and then 40% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	40% Coinsurance after Deductible
Hospice Services	40% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 40% Coinsurance after Deductible
Inpatient Physician and Surgical Services	40% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	40% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	40% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$50 Copayment per visit before Deductible and then 40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 40% Coinsurance after Deductible
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	40% Coinsurance after Deductible
Durable Medical Equipment	40% Coinsurance after Deductible
Prosthetics	40% Coinsurance after Deductible
Orthotic Devices	40% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	40% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$50 Copayment per visit before Deductible and then 40% Coinsurance after Deductible
Specialty Physician	40% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	40% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	40% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	40% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	40% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$10 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$25 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$30 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$75 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver HSA

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,750 per Plan Year
Per Family	$5,500 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$3,600 per Plan Year
Per Family	$7,200 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician " or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	10% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	10% Coinsurance after Deductible
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	10% Coinsurance after Deductible
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Tier 5 (Specialty)	35% Coinsurance after Deductible
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Value

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,500 per Plan Year
Per Family	$5,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,350 per Plan Year
Per Family	$12,700 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room – *Cost sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$40 Copayment per visit
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$40 Copayment per visit
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Enhanced

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,000 per Plan Year
Per Family	$4,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$5,750 per Plan Year
Per Family	$11,500 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	20% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Dental Services for Accidental Injury	20% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	20% Coinsurance after Deductible
Radiology Services	20% Coinsurance after Deductible
X-ray Services	20% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 20% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	20% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	20% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$30 Copayment per visit
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$30 Copayment per visit
Specialty Physician	20% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	20% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	20% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver HSA - CSR 73

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,000 per Plan Year
Per Family	$4,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$3,600 per Plan Year
Per Family	$7,200 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	10% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	10% Coinsurance after Deductible
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	10% Coinsurance after Deductible
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Tier 5 (Specialty)	30% Coinsurance after Deductible
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Value – CSR 73

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,500 per Plan Year
Per Family	$5,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$4,500 per Plan Year
Per Family	$9,000 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$30 Copayment per visit
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$30 Copayment per visit
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Enhanced – CSR 73

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,000 per Plan Year
Per Family	$4,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$4,500 per Plan Year
Per Family	$9,000 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	20% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Dental Services for Accidental Injury	20% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	20% Coinsurance after Deductible
Radiology Services	20% Coinsurance after Deductible
X-ray Services	20% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 20% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	20% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	20% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$30 Copayment per visit
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$30 Copayment per visit
Specialty Physician	20% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	20% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	20% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver HSA – CSR 87

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$800 per Plan Year
Per Family	$1,600 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$1,200 per Plan Year
Per Family	$2,400 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician " or "Primary Care Physician" provisions in this Schedule . For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	10% Coinsurance after Deductible
Urgent Care Center Services	10% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	10% Coinsurance after Deductible
Delivery and Inpatient Services	10% Coinsurance after Deductible
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	10% Coinsurance after Deductible
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Tier 5 (Specialty)	30% Coinsurance after Deductible
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Value – CSR 87
Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$750 per Plan Year
Per Family	$1,500 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$1,500 per Plan Year
Per Family	$3,000 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the

Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician " or "Primary Care Physician" provisions in this Schedule . For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	$75 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$20 Copayment per visit
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$20 Copayment per visit
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Enhanced – CSR 87

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$750 per Plan Year
Per Family	$1,500 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$1,500 per Plan Year
Per Family	$3,000 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$500 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$500 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$200 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	$75 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$500 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$10 Copayment per visit
Delivery and Inpatient Services	$500 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$10 Copayment per visit
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver HSA – CSR 94
Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$400 per Plan Year
Per Family	$800 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$500 per Plan Year
Per Family	$1,000 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be

Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician " or "Primary Care Physician" provisions in this Schedule . For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	10% Coinsurance after Deductible
Urgent Care Center Services	10% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	10% Coinsurance after Deductible
Delivery and Inpatient Services	10% Coinsurance after Deductible
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	10% Coinsurance after Deductible
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Tier 5 (Specialty)	30% Coinsurance after Deductible
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Value – CSR 94

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$200 per Plan Year
Per Family	$400 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$600 per Plan Year
Per Family	$1,200 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$200 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$200 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$100 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	$40 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$200 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$10 Copayment per visit
Delivery and Inpatient Services	$200 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$10 Copayment per visit
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Enhanced – CSR 94

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$150 per Plan Year
Per Family	$300 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$650 per Plan Year
Per Family	$1,300 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$200 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$200 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$100 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	$40 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$200 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$10 Copayment per visit
Delivery and Inpatient Services	$200 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$10 Copayment per visit
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Gold Value

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$750 per Plan Year
Per Family	$1,500 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,000 per Plan Year
Per Family	$12,000 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	20% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient Services	$500 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$500 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Dental Services for Accidental Injury	20% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or “Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	20% Coinsurance after Deductible
Radiology Services	20% Coinsurance after Deductible
X-ray Services	20% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$200 Copayment per visit after Deductible and then 20% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$500 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	20% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	20% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$20 Copayment per visit
Delivery and Inpatient Services	$500 Copayment per admission after Deductible and then 20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$20 Copayment per visit
Specialty Physician	$50 Copayment per visit before Deductible and then 20% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	20% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	20% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$8 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$20 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$24 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$60 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Bronze HSA – Limited Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$4,500 per Plan Year
Per Family	$9,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,350 per Plan Year
Per Family	$12,700 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	20% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Dental Services for Accidental Injury	20% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule . For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	20% Coinsurance after Deductible
Radiology Services	20% Coinsurance after Deductible
X-ray Services	20% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 20% Coinsurance after Deductible
Urgent Care Center Services	20% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	20% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	20% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	20% Coinsurance after Deductible
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	20% Coinsurance after Deductible
Specialty Physician	20% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	20% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	20% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$10 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$25 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$30 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$75 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Tier 5 (Specialty)	40% Coinsurance after Deductible
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Bronze Value – Limited Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$6,000 per Plan Year
Per Family	$12,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,350 per Plan Year
Per Family	$12,700 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	25% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	25% Coinsurance after Deductible
Inpatient Services	$1,500 Copayment per admission after Deductible and then 25% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	25% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$1,500 Copayment per admission after Deductible and then 25% Coinsurance after Deductible
Dental Services for Accidental Injury	25% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	25% Coinsurance after Deductible
Radiology Services	25% Coinsurance after Deductible
X-ray Services	25% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$350 Copayment per visit after Deductible and then 25% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	25% Coinsurance after Deductible
Hospice Services	25% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$1,500 Copayment per admission after Deductible and then 25% Coinsurance after Deductible
Inpatient Physician and Surgical Services	25% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	25% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	25% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$40 Copayment per visit
Delivery and Inpatient Services	$1,500 Copayment per admission after Deductible and then 25% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	25% Coinsurance after Deductible
Durable Medical Equipment	25% Coinsurance after Deductible
Prosthetics	25% Coinsurance after Deductible
Orthotic Devices	25% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	25% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	25% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$40 Copayment per visit
Specialty Physician	25% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	25% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	25% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	25% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	25% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	25% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	25% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$10 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$25 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$30 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$75 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Bronze Enhanced – Limited Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$5,000 per Plan Year
Per Family	$10,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,350 per Plan Year
Per Family	$12,700 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	40% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	40% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 40% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 40% Coinsurance after Deductible
Dental Services for Accidental Injury	40% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	40% Coinsurance after Deductible
Radiology Services	40% Coinsurance after Deductible
X-ray Services	40% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$275 Copayment per visit after Deductible and then 40% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit before Deductible and then 40% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	40% Coinsurance after Deductible
Hospice Services	40% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 40% Coinsurance after Deductible
Inpatient Physician and Surgical Services	40% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	40% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	40% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$50 Copayment per visit before Deductible and then 40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 40% Coinsurance after Deductible
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	40% Coinsurance after Deductible
Durable Medical Equipment	40% Coinsurance after Deductible
Prosthetics	40% Coinsurance after Deductible
Orthotic Devices	40% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	40% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$50 Copayment per visit before Deductible and then 40% Coinsurance after Deductible
Specialty Physician	40% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	40% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	40% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	40% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	40% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	40% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$10 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$25 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$30 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$75 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	30% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	40% Coinsurance after Deductible
Tier 5 (Specialty)	40% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Silver HSA – Limited Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,750 per Plan Year
Per Family	$5,500 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$3,600 per Plan Year
Per Family	$7,200 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician " or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	10% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	10% Coinsurance after Deductible
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	10% Coinsurance after Deductible
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Tier 5 (Specialty)	35% Coinsurance after Deductible
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Silver Value – Limited Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,500 per Plan Year
Per Family	$5,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,350 per Plan Year
Per Family	$12,700 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room – *Cost sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$40 Copayment per visit
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$40 Copayment per visit
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Silver Enhanced – Limited Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,000 per Plan Year
Per Family	$4,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$5,750 per Plan Year
Per Family	$11,500 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	20% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Dental Services for Accidental Injury	20% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	20% Coinsurance after Deductible
Radiology Services	20% Coinsurance after Deductible
X-ray Services	20% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 20% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	20% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	20% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$30 Copayment per visit
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$30 Copayment per visit
Specialty Physician	20% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	20% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	20% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	25% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	35% Coinsurance after Deductible
Tier 5 (Specialty)	35% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Gold Value – Limited Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$750 per Plan Year
Per Family	$1,500 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$6,000 per Plan Year
Per Family	$12,000 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	20% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient Services	$500 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$500 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Dental Services for Accidental Injury	20% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or “Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	20% Coinsurance after Deductible
Radiology Services	20% Coinsurance after Deductible
X-ray Services	20% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$200 Copayment per visit after Deductible and then 20% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$500 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	20% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	20% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$20 Copayment per visit
Delivery and Inpatient Services	$500 Copayment per admission after Deductible and then 20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$20 Copayment per visit
Specialty Physician	$50 Copayment per visit before Deductible and then 20% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	20% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	20% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$8 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$20 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$24 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$60 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Bronze HSA – Zero Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	No Charge
Behavioral Health Services	
Outpatient Services	No Charge
Inpatient Services	No Charge
Substance Abuse Disorder Outpatient Services	No Charge
Substance Abuse Disorder Inpatient Services	No Charge
Dental Services for Accidental Injury	No Charge
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	No Charge
Radiology Services	No Charge
X-ray Services	No Charge

Benefit	Cost Sharing per Covered Person
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	No Charge
Urgent Care Center Services	No Charge
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	No Charge
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	No Charge
Hospice Services	No Charge
Inpatient Services	
Inpatient Facility Services	No Charge
Inpatient Physician and Surgical Services	No Charge
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	No Charge
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	No Charge
Maternity Services	
Prenatal and Postnatal Care	No Charge
Delivery and Inpatient Services	No Charge
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	No Charge
Durable Medical Equipment	No Charge
Prosthetics	No Charge
Orthotic Devices	No Charge
Outpatient Services	
Outpatient Facility	No Charge
Outpatient Surgery Physician/Surgical Services	No Charge
Physician Visits	
Primary Care Physician	No Charge
Specialty Physician	No Charge

Benefit	Cost Sharing per Covered Person
Preventive Care Services	No Charge
Surgical Services	No Charge
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	No Charge
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	No Charge
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	No Charge
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	No Charge
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable

Benefit	Cost Sharing per Covered Person
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount
Transportation and Lodging	No Charge Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	No Charge Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge

Benefit	Cost Sharing per Covered Person
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Bronze Value – Zero Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	No Charge
Behavioral Health Services	
Outpatient Services	No Charge
Inpatient Services	No Charge
Substance Abuse Disorder Outpatient Services	No Charge
Substance Abuse Disorder Inpatient Services	No Charge
Dental Services for Accidental Injury	No Charge
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	No Charge
Radiology Services	No Charge

Benefit	Cost Sharing per Covered Person
X-ray Services	No Charge
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	No Charge
Urgent Care Center Services	No Charge
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	No Charge
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	No Charge
Hospice Services	No Charge
Inpatient Services	
Inpatient Facility Services	No Charge
Inpatient Physician and Surgical Services	No Charge
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	No Charge
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	No Charge
Maternity Services	
Prenatal and Postnatal Care	No Charge
Delivery and Inpatient Services	No Charge
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	No Charge
Durable Medical Equipment	No Charge
Prosthetics	No Charge
Orthotic Devices	No Charge
Outpatient Services	
Outpatient Facility	No Charge
Outpatient Surgery Physician/Surgical Services	No Charge

Benefit	Cost Sharing per Covered Person
Physician Visits	
Primary Care Physician	No Charge
Specialty Physician	No Charge
Preventive Care Services	No Charge
Surgical Services	No Charge
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	No Charge
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	No Charge
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	No Charge
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	No Charge
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable

Benefit	Cost Sharing per Covered Person
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount
Transportation and Lodging	No Charge Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	No Charge Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge

Benefit	Cost Sharing per Covered Person
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Bronze Enhanced – Zero Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	No Charge
Behavioral Health Services	
Outpatient Services	No Charge
Inpatient Services	No Charge
Substance Abuse Disorder Outpatient Services	No Charge
Substance Abuse Disorder Inpatient Services	No Charge
Dental Services for Accidental Injury	No Charge
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	No Charge
Radiology Services	No Charge

Benefit	Cost Sharing per Covered Person
X-ray Services	No Charge
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	No Charge
Urgent Care Center Services	No Charge
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	No Charge
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	No Charge
Hospice Services	No Charge
Inpatient Services	
Inpatient Facility Services	No Charge
Inpatient Physician and Surgical Services	No Charge
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	No Charge
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	No Charge
Maternity Services	
Prenatal and Postnatal Care	No Charge
Delivery and Inpatient Services	No Charge
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	No Charge
Durable Medical Equipment	No Charge
Prosthetics	No Charge
Orthotic Devices	No Charge
Outpatient Services	
Outpatient Facility	No Charge
Outpatient Surgery Physician/Surgical Services	No Charge

Benefit	Cost Sharing per Covered Person
Physician Visits	
Primary Care Physician	No Charge
Specialty Physician	No Charge
Preventive Care Services	No Charge
Surgical Services	No Charge
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	No Charge
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	No Charge
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	No Charge
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	No Charge
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable

Benefit	Cost Sharing per Covered Person
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount
Transportation and Lodging	No Charge Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	No Charge Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge

Benefit	Cost Sharing per Covered Person
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Silver HSA – Zero Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	No Charge
Behavioral Health Services	
Outpatient Services	No Charge
Inpatient Services	No Charge
Substance Abuse Disorder Outpatient Services	No Charge
Substance Abuse Disorder Inpatient Services	No Charge
Dental Services for Accidental Injury	No Charge
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	No Charge
Radiology Services	No Charge
X-ray Services	No Charge

Benefit	Cost Sharing per Covered Person
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	No Charge
Urgent Care Center Services	No Charge
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	No Charge
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	No Charge
Hospice Services	No Charge
Inpatient Services	
Inpatient Facility Services	No Charge
Inpatient Physician and Surgical Services	No Charge
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	No Charge
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	No Charge
Maternity Services	
Prenatal and Postnatal Care	No Charge
Delivery and Inpatient Services	No Charge
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	No Charge
Durable Medical Equipment	No Charge
Prosthetics	No Charge
Orthotic Devices	No Charge
Outpatient Services	
Outpatient Facility	No Charge
Outpatient Surgery Physician/Surgical Services	No Charge
Physician Visits	
Primary Care Physician	No Charge
Specialty Physician	No Charge

Benefit	Cost Sharing per Covered Person
Preventive Care Services	No Charge
Surgical Services	No Charge
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	No Charge
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	No Charge
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	No Charge
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	No Charge
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable

Benefit	Cost Sharing per Covered Person
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount
Transportation and Lodging	No Charge Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	No Charge Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge

Benefit	Cost Sharing per Covered Person
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Silver Value – Zero Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	No Charge
Behavioral Health Services	
Outpatient Services	No Charge
Inpatient Services	No Charge
Substance Abuse Disorder Outpatient Services	No Charge
Substance Abuse Disorder Inpatient Services	No Charge
Dental Services for Accidental Injury	No Charge
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	No Charge
Radiology Services	No Charge

Benefit	Cost Sharing per Covered Person
X-ray Services	No Charge
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	No Charge
Urgent Care Center Services	No Charge
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	No Charge
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	No Charge
Hospice Services	No Charge
Inpatient Services	
Inpatient Facility Services	No Charge
Inpatient Physician and Surgical Services	No Charge
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	No Charge
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	No Charge
Maternity Services	
Prenatal and Postnatal Care	No Charge
Delivery and Inpatient Services	No Charge
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	No Charge
Durable Medical Equipment	No Charge
Prosthetics	No Charge
Orthotic Devices	No Charge
Outpatient Services	
Outpatient Facility	No Charge
Outpatient Surgery Physician/Surgical Services	No Charge

Benefit	Cost Sharing per Covered Person
Physician Visits	
Primary Care Physician	No Charge
Specialty Physician	No Charge
Preventive Care Services	No Charge
Surgical Services	No Charge
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	No Charge
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	No Charge
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	No Charge
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	No Charge
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable

Benefit	Cost Sharing per Covered Person
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount
Transportation and Lodging	No Charge Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	No Charge Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge

Benefit	Cost Sharing per Covered Person
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Silver Enhanced – Zero Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	No Charge
Behavioral Health Services	
Outpatient Services	No Charge
Inpatient Services	No Charge
Substance Abuse Disorder Outpatient Services	No Charge
Substance Abuse Disorder Inpatient Services	No Charge
Dental Services for Accidental Injury	No Charge
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	No Charge
Radiology Services	No Charge

Benefit	Cost Sharing per Covered Person
X-ray Services	No Charge
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	No Charge
Urgent Care Center Services	No Charge
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	No Charge
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	No Charge
Hospice Services	No Charge
Inpatient Services	
Inpatient Facility Services	No Charge
Inpatient Physician and Surgical Services	No Charge
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	No Charge
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	No Charge
Maternity Services	
Prenatal and Postnatal Care	No Charge
Delivery and Inpatient Services	No Charge
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	No Charge
Durable Medical Equipment	No Charge
Prosthetics	No Charge
Orthotic Devices	No Charge
Outpatient Services	
Outpatient Facility	No Charge
Outpatient Surgery Physician/Surgical Services	No Charge

Benefit	Cost Sharing per Covered Person
Physician Visits	
Primary Care Physician	No Charge
Specialty Physician	No Charge
Preventive Care Services	No Charge
Surgical Services	No Charge
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	No Charge
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	No Charge
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	No Charge
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	No Charge
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable

Benefit	Cost Sharing per Covered Person
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount
Transportation and Lodging	No Charge Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	No Charge Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge

Benefit	Cost Sharing per Covered Person
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

IU Health Plans Gold Value – Zero Cost Sharing

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$0 per Plan Year
Per Family	$0 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	No Charge
Behavioral Health Services	
Outpatient Services	No Charge
Inpatient Services	No Charge
Substance Abuse Disorder Outpatient Services	No Charge
Substance Abuse Disorder Inpatient Services	No Charge
Dental Services for Accidental Injury	No Charge
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	No Charge
Radiology Services	No Charge

Benefit	Cost Sharing per Covered Person
X-ray Services	No Charge
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	No Charge
Urgent Care Center Services	No Charge
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	No Charge
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	No Charge
Hospice Services	No Charge
Inpatient Services	
Inpatient Facility Services	No Charge
Inpatient Physician and Surgical Services	No Charge
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	No Charge
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	No Charge
Maternity Services	
Prenatal and Postnatal Care	No Charge
Delivery and Inpatient Services	No Charge
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	No Charge
Durable Medical Equipment	No Charge
Prosthetics	No Charge
Orthotic Devices	No Charge
Outpatient Services	
Outpatient Facility	No Charge
Outpatient Surgery Physician/Surgical Services	No Charge

Benefit	Cost Sharing per Covered Person
Physician Visits	
Primary Care Physician	No Charge
Specialty Physician	No Charge
Preventive Care Services	No Charge
Surgical Services	No Charge
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	No Charge
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	No Charge
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	No Charge
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	No Charge
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	No Charge

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable

Benefit	Cost Sharing per Covered Person
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount
Transportation and Lodging	No Charge Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	No Charge Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge

Benefit	Cost Sharing per Covered Person
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	No Charge
Tier 2 (Non-Preferred Generic)	No Charge
Tier 3 (Preferred Brand Name)	No Charge
Tier 4 (Non-Preferred Brand Name)	No Charge
Tier 5 (Specialty)	No Charge
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Rate Information

Rate data applies to filing.

Filing Method: New filing
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision:
Filing Method of Last Filing: new filing

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
IU Health Plans	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Rate Review Detail

COMPANY:

Company Name: IU Health Plans
HHS Issuer Id: 33380

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
IU Health Plans Individual Product	33380IN002	33380-195600	1462

Trend Factors: IU Health Plans did not have any base period experience thus a manual rate was used to develop the premium rates. Our manual rates represent fully-completed calendar year 2012 claims, thus allowed costs were trended from the midpoint of 2012 to the midpoint of 2015 using an annual trend rate of 7.4%

FORMS:

New Policy Forms: IU Health Plans Individual Product - Adult Policy, IU Health Plans Individual Product - Child Only Policy
Affected Forms: Not Applicable
Other Affected Forms: Not Applicable

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 17,544
Benefit Change: None
Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium: 0.00
Total Incurred Claims: 0.00
Annual $: Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium: 10,156,621.40
Projected Incurred Claims: 7,953,385.33
Annual $: Min: 173.42 Max: 1,356.12 Avg: 569.17

SERFF Tracking #:	*IUHP-129535085*	***State Tracking #:***	*13164.1-INDIV-POLICY (01/2015)*	***Company Tracking #:***	

State:	*Indiana*	***Filing Company:***	*IU Health Plans*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*IU Health Plans Individual Product*		
Project Name/Number:	*Marketplace Ind 2015/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Actuarial Memorandum	13164.1-Indiv-Policy-Adult (01/2015), 13164.1-Indiv-Policy-Child (01/2015)	New		FINAL IUHP 2015 Individual Actuarial Memorandum - IDOI Response_08.01.2014.pdf,

Actuarial Memorandum

Indiana University Health Plans, Inc.

Individual Health Rate Filing

Effective January 1, 2015 through December 31, 2015

Form: 13164.1-Indiv-Policy-Adult (01/2015)

13164.1-Indiv-Policy-Child (01/2015)

Submitted: August 1, 2014

TABLE OF CONTENTS

1) General Information 3
2) Proposed Rate Increase(s) 4
3) Experience Period Premium and Claims 4
4) Benefit Categories 5
5) Projection Factors 5
6) Credibility Manual Rate Development 5
7) Credibility of Experience 7
8) Paid to Allowed Ratio 7
9) Risk Adjustment and Reinsurance 8
10) Non-Benefit Expenses and Profit & Risk 8
11) Projected Loss Ratio 9
12) Single Risk Pool 10
13) Index Rate 10
14) Market Adjusted Index Rate 10
15) Plan Adjusted Index Rates 11
16) Calibration 12
17) Consumer Adjusted Premium Rate Development 13
18) AV Metal Values 13
19) AV Pricing Values 14
20) Membership Projections 14
21) Terminated Products 14
22) Plan Type 14
23) Warning Alerts 14
24) Company Financial Position 14
25) Reliance 15
26) Actuarial Certification 15

1) General Information

Overview

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template (URRT), which supports compliance with the market rating rules and reasonableness of applicable rate increases.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with State of Indiana statutes and provisions of the Affordable Care Act (ACA). This memorandum documents the development of the Individual rates for Indiana University Health Plans, Inc. (IUHP). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This information may not be appropriate for other purposes.

This information is intended for use by the State of Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of IUHP's Individual rate filing. However, we recognize that this certification may become a public document. PwC makes no representations or warranties regarding the contents of this memorandum to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for IUHP by PwC that would result in the creation of any duty or liability under any theory of law by PwC or its employees to third parties.

These results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

Company Identifying Information

- Company Legal Name: Indiana University Health Plans, Inc.
- State: The State of Indiana has regulatory authority over these policies
- HIOS Issuer ID: 33380
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: Eric Neuville, Vice President Product Development and Innovation
- Primary Contact Telephone Number: (317) 963-1835
- Primary Contact Email Address: eneuville@iuhealth.org

Certifying Actuary Contact Information

- Primary Contact Name: Robert Macagnano, PwC
- Primary Contact Telephone Number: (973) 236-4082
- Primary Contact Email Address: robert.macagnano@us.pwc.com

Benefit Summary

IUHP will be offering three Bronze, three Silver, and one Gold HMO products. A summary of the major provisions of each plan are provided in Appendix A.

Premium Guarantee Provision

Premiums are guaranteed not to change through December 31, 2015.

Renewability

The policy is renewable by paying the applicable renewal premiums unless the policyholder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability

The rates will apply to new business. Subsequent renewal business will be subject to rates filed for our 2016 rate development.

Premium Modalization

Premiums will be collected only on a monthly basis.

Trend Assumption

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2) Proposed Rate Increase(s)

This is a new filing therefore no rate increase assumption is included in this filing. Subsequent rate increases beginning with effective dates of January 1, 2016 will be filed in the future.

3) Experience Period Premium and Claims

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

4) Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.

Capitation: Includes capitated services for pediatric vision benefits.

Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

5) Projection Factors

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6) Credibility Manual Rate Development

The PwC Rating Model was used as the basis to develop the manual rates. Our model was developed using two primary sources:

- Commercial Truven Health MarketScan® Research Databases for U.S. members and providers. The database contains full enrollment and claims information with standard medical coding which allows for cost and utilization information by service category (inpatient, outpatient hospital, hospice, home health, professional, prescription drugs, etc.). The database consists of the experience from 53 million Commercial eligible participants. The data can be extracted down to the member's state and MSA level. For the Indiana Commercial market, there were approximately 1.5 million exposed life years' worth of data crossing all ages, genders and employment statuses (active, COBRA, disabled and retired). Nationwide, the databases have over 100 unique data contributors so it is not skewed to any one payer.
- OptumInsight (Optum) Comprehensive Pricing Model® provides benchmark data and pricing capabilities for Commercial health plans. It factors in health plan features such as deductibles, copays, out-of-pocket maximums, covered services, etc. The model uses normative data and benefit details to arrive at an allowed cost per member per month. The

normative benchmarking utilization metrics within the model are developed from Optum's database of Commercial (under 65) health plan experience of approximately 20 million life years. The model experience was adjusted to reflect the Indiana marketplace.

Since both the Truven and Optum data sources represent fully-completed calendar year 2012 claims, allowed costs were trended to the midpoint of calendar year 2015 using an annual trend rate of 7.4%.

The allowed costs component of the manual rates was increased by 2% to account for expected changes in covered benefits due to the Essential Health Benefits (EHB) requirements. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- State mandated benefits included in the EHB that previously only applied to group coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

In our May 9, 2014 filing, we noted that the Indiana Department of Insurance (IDOI) was expected to provide additional information pertaining to the Medicaid Spend-Down population. IUHP also reserved the right to revise their initial filing to reflect any additional data. Subsequent to IUHP's May 9, 2014 filing, the IDOI released additional SFY 2013 information pertaining to the Medicaid Spend-Down population which included the following:

- Summary of unique individuals, Medicaid allowed, Medicaid paid, and billed charges by age band, gender, and FPL % category
- Summary of the Medicaid allowed, Medicaid paid, and Billed charges for each unique individual
- Summary of unique individuals, Medicaid allowed, Medicaid paid, and billed charges by county

The manual rates were increased by 5.2% to reflect the entrance of approximately 7,000 Medicaid Spend-Down beneficiaries into the Indiana Health Insurance Exchange. This adjustment was based on the assumption that IUHP's penetration of the Medicaid Spend-Down population would be similar to their assumed penetration of the general population for the counties included in IUHP's proposed service area.

There will also be new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services. Pent up demand has been shown to increase costs in the first year of enrollment for those

previously uninsured. Based on analysis of programs serving a similar population, it appears that the claims are higher in the first six to 12 months that an individual is newly insured. After this initial period, the claims experience tends to revert to the average level for the market. The total effect is uncertain and may be offset by some new enrollees having reduced utilization as they may not fully understand new or increased coverage. Therefore, we have included an adjustment within our manual rate development for pent up demand of 3.0%.

The following adjustments were made to calibrate the pricing model to the expected population:

- Rating region
- Expected demographics
- Expected morbidity
- Contractual Agreements with healthcare providers
- Expected utilization management savings
- Benefit plan designs

Some benefits will be reimbursed under a capitation arrangement. The provider reimbursement adjustment to the pricing model was developed to account for the cost of capitated services.

The manual rates were also adjusted upward by a factor of 1.005 to account for the likelihood that some enrollees may not pay their premiums due during the first month of the 90-day grace period. This was calculated assuming a 15% rate of non-payment on one-twelfth of the annual premium due for 80% of the Individual population (those eligible for Advance Payments of a Premium Tax Credit). The amount of premium at risk is only on the portion that IUHP does not receive via direct subsidy, estimated to be 50% (0.15 x 1/12 x 0.80 x 0.50 = 0.005). The 15% represents our assumption regarding the small portion of enrollees that we believe will knowingly take advantage of the grace period provision. The 80% represents the portion of enrollees in the 2015 Individual marketplace that we assume will be eligible for premium subsidies based on income level. On May 1, 2014 the Department of Health and Human Services reported that as of April 19, 2014, 89% of those enrolled in the Indiana exchange were eligible for federal assistance. Our assumption is that this percentage will decrease during 2015.

7) Credibility of Experience

IUHP has not previously operated in the individual market. As a result the “Experience Period” section of Worksheet 1 of the URRT has not been populated. Similarly, the projection factors (cells J24:M29 on Worksheet 1) have also been left blank. The service category PMPMs shown in the “Credibility Manual” section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

8) Paid to Allowed Ratio

The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT calculates the PMPM costs on both an allowed and paid basis. The “Paid to Allowed Average Factor in Projection Period” shown on Worksheet 1, Section III of the URRT is developed by membership-weighted EHB paid claims divided by membership-weighted EHB allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

9) Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, IUHP is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value. Therefore, no risk adjustment PMPM payment is assumed for 2015.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only)

The Federal transitional reinsurance program is a temporary risk mitigation program expected to reduce costs for insurance issuers. The 2015 reinsurance program has an attachment point of $70,000 and a maximum coverage limit of $250,000 per member. The Department of Health and Human Services will reimburse insurance issuers 50% of paid costs between the attachment point and maximum coverage limit.

Allowed claims were reduced by 7.0% to account for the anticipated 2015 reimbursements from this temporary program. This estimate was developed using projected paid claims, a claims probability distribution calibrated to the expected average claim levels for the 2015 Individual market, and the federal program guidelines summarized above. The expected reinsurance reimbursements are $45.48 PMPM. Applying the 2015 transitional reinsurance charge of $3.67 PMPM yields a net reinsurance cost of $41.81 PMPM.

Projected Net Cost of Private Reinsurance

The projected net cost of private reinsurance for 2015 is $0.00 PMPM since IUHP does not intend to purchase private reinsurance.

10) Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

IUHP developed their expected administrative expenses based on: a) current administrative expenses for their Medicare line of business adjusting for any expected differences for their Commercial products, and b) a review of 2014 Rate Filings for Individual Exchange products. A summary of IUHP's assumptions is as follows:

- Administrative expenses (excluding Sales and Marketing expenses): 10.50% of premium
- Sales and Marketing expenses (including commissions): $6.18 PMPM

These administrative expenses are allocated proportionally by plan.

Quality Improvement Expenses

At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. Therefore, no explicit Quality Improvement expenses were assumed.

Profit & Risk Margin

The proposed rates reflect a profit & risk margin of 3.0% of premium. This load was applied to all products and plans.

Taxes and Fees

A summary of the assumed taxes and fees are summarized below:

PMPM Basis

- Transitional reinsurance charge: $3.67 PMPM ($44.00 per member per year)
- Risk adjustment user fee: $0.08 PMPM
- PCORI fee: $0.17 PMPM ($2.00 per member per year)

Percentage of Premium Basis

- Health insurance exchange fee: 3.15% of premium reflecting IUHP's assumption that 90% of their expected 2015 business will be sold through the exchange
- ACA issuer fee: 2.00% of premium
- Premium tax: 1.30% of premium

11) Projected Loss Ratio

The overall projected medical loss ratio for 2015 is 84.9%. This calculation excludes regulatory fees and taxes. At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. As a result, we have not included an adjustment in the MLR calculation for these expenses. It is IUHP's intent to identify their Quality Improvement expenses for purposes of submitting their MLR-related filings and calculating related rebates, if any. The following table shows the calculation.

a)	Incurred Claims Net of Cost Sharing	$439.86
b)	Transitional Reinsurance Reimbursement	($45.48)
c)	Reinsurance Charge	$3.67
d)	Quality Improvement Expenses	$0.00
e)	Worksheet 1 Projected Incurred Claims (a+b+c+d)	$398.05
f)	Administrative Expenses	$59.23
g)	Profit & Risk Margin	$15.16
h)	Regulatory Taxes and Fees (excluding reinsurance charge)	$32.84
i)	Gross Premium (e+f+g+h)	$505.27
j)	Medical Loss Ratio (e/(i-c-h))	84.9%

12) Single Risk Pool

IUHP has not previously operated in the Individual market and thus does not have any claims experience to develop its own Single Risk Pool. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

13) Index Rate

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the Index Rate for the Experience Period has been left blank.

The Index Rate of $649.68 for the 2015 Projection Period represents the overall projected allowed costs PMPM for providing Essential Health Benefits for the Single Risk Pool. Since this is a new product, the index rate was developed based on a manual rate as described above in the Credibility Manual Rate Development section. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

14) Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic

characteristics of the Single Risk Pool. In other words, the Market Adjusted Index Rate is not calibrated.

The development of the Federal reinsurance program and risk adjustments was described above in the Risk Adjustment and Reinsurance section. The development of the Exchange user fee adjustment was described above in the Non-Benefit Expenses and Profit & Risk section.

Index Rate	$649.68
Reinsurance Reimbursements (7.0% of Allowed Claims – Index Rate)	($45.48)
Reinsurance Premiums	$ 3.67
Risk Adjustment	$ 0.00
Exchange user fee (3.15% of average premium for Single Risk Pool)	$ 15.92
Market Adjusted Index Rate	$623.78

15) Plan Adjusted Index Rates

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the Part I Unified Rate Review Template in 2015. These Plan Adjusted Index Rates have been adjusted to remove the portion of the allowed cost that is expected to be recouped through the tobacco surcharge. The average tobacco surcharge for the Single Risk Pool is approximately 1.4%.

The Plan Adjusted Index Rates reflect the average demographic characteristics of the Single Risk Pool. In other words, the Plan Adjusted Index Rates are not calibrated.

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

- Actuarial value and cost sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)
- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

Only the actuarial value and cost sharing & distribution and administrative costs adjustments were applicable to IUHP.

Actuarial Value and Cost Sharing Adjustment

This adjustment includes three components:

- Removal of tobacco surcharge - the average tobacco surcharge factor was applied to the average allowed costs for the Single Risk Pool
- Benefit richness utilization adjustments - The reference plan underlying our pricing was a Silver plan. Benefit richness utilization adjustments were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge). These

adjustments were based on the values published in the Federal Register payment notice, normalized to the Silver plan level. The adjustments for each metallic tier are as follows:

- Bronze = 1.00 / 1.03 = 0.9709
- Silver = 1.00 / 1.00 = 1.0000
- Gold = 1.08 / 1.03 = 1.0485

- Cost Sharing - The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT was used to calculate the cost sharing percentage for each plan. These cost sharing percentages were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge and applying the benefit richness utilization adjustments). The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

Adjustment for Distribution and Administrative Costs

Fixed and variable costs as described in the Non-Benefit Expenses and Profit & Risk section were included in this adjustment as follows:

- Fixed costs: Risk adjustment user fee, PCORI fee, and sales & marketing expenses
- Variable costs (% of premium): Administrative expenses, profit & risk margin, ACA issuer fee, and premium taxes. The percentages applied did not vary by plan.

Appendix D shows the development of the Plan Adjusted Index Rates.

16) Calibration

The Plan Adjusted Index Rates (which are based on the Single Risk Pool) were calibrated to apply the allowable rating factors in order to calculate Consumer Adjusted Premium Rates. The calibration by age and geography is described below.

Age Curve Calibration

The methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology and conforms with the rating rules specified in 45 CFR 147.102.

The expected membership distribution by age band was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. A uniform distribution within each age band was also assumed. A weighted average age factor of 1.685 for the Single Risk Pool was also determined by applying the membership distribution to the Federal age curve. This represents a rounded weighted average age of 49. Appendix C shows the development of the weighted average age factor.

The Plan Index Rates were calibrated by dividing by 1.685. This calibration factor does not vary by plan.

Geographic Factor Calibration

A geographic factor calibration was not required since the weighted average of the geographic factors equals 1.0. The Geographic (rating area) factors were developed based upon the network characteristics for unit cost and utilization management in each of the established rating areas. Based upon the expected distribution of enrolment by area, the area factors reflect the Single Risk Pool results consistent with the URRT.

Appendix D shows how the calibration adjustments were applied to the Plan Adjusted Index Rates.

17) Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography if necessary, and applying the rating factors specified by 45 CFR Part 147, §147.102. The following adjustments are allowable under this rule:

- Whether the plan coverage covers an individual or family (issuers must cover any eligible individual and/or eligible family that requests coverage per the guaranteed issue requirement of the ACA); this is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor
- Rating area
- Age – reflecting the applicable age curve
- Tobacco status

The rating factors (shown in Appendix C) are applied at an individual level and added together to calculate the family rate, with the exception that no more than 3 covered children under the age of 21 are charged a rate. Adjustment for family size is in accordance with Federal rules. The examples in Appendix E show how the rating factors are applied to the calibrated Plan Adjusted Index Rate.

18) AV Metal Values

The Federal AV calculator was used without any modifications to generate the Metal Values included in Worksheet 2 of the URRT. Please refer to Appendix F for screen shots showing the AV calculations for each plan.

19) AV Pricing Values

The Silver Value plan was selected as the fixed reference plan and serves as the basis for the AV Pricing Values. Please refer to Appendix C for the AV Pricing Values for each plan which are also included in Worksheet 2, Section I of the URRT. The AV Pricing Value for each plan reflects the relative impact of the plan's cost-sharing amounts, expected impact on enrollee utilization due to benefit richness (excluding impact of morbidity), expected additional cost of non-EHB, and administrative expenses (excluding health insurance exchange user fees).

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the PwC Rating Model as described above in the Credibility Manual Rate Development section was used to develop the benefit relativities for the AV Pricing Values.

20) Membership Projections

Membership projections were based on market penetration assumptions provided by IUHP. These assumptions reflected the uninsured and individual market populations by county, income level, and other characteristics such as the presence of IUHP facilities and delivery system within a given county.

The expected membership distribution by age band and metallic tier was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. For the Silver plans, the portion of the projected enrollment that will be eligible for CSR subsidies at each subsidy level was based on the income level detail in the market penetration analysis provided by IUHP.

Summaries of the projected membership by age, metallic tier, and CSR subsidy level are shown in Appendix B.

21) Terminated Products

Not applicable. IUHP does not currently have Individual plans in the State of Indiana.

22) Plan Type

All plans listed types in Worksheet 2, Section I of the URRT correctly describe IUHP's plans as "HMO".

23) Warning Alerts

There were no warnings generated on Worksheet 2 of in the URRT.

24) Company Financial Position

Please see Appendix G for information regarding the capital and surplus position of IUHP.

25) Reliance

In the preparation of this filing, I have relied upon data provided by Eric Neuville (Vice President Product Development and Innovation), Connie Brown (CFO and COO), and IUHP management. I did not audit this data but did review it for reasonableness. This information includes but is not limited to the following items:

- Administrative expense projections (including commissions)
- Provider reimbursement levels (including capitation arrangements)
- Projected enrollment
- Projected pharmacy discounts, unit costs and rebates
- Financial statement information

26) Actuarial Certification

I, Robert Macagnano, FSA, MAAA, am affiliated with PricewaterhouseCoopers LLP (PwC). I am a Member of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinion contained herein. This filing is prepared on behalf of Indiana University Health Plans, Inc. (the "Company").

I certify that this filing has been prepared in accordance with the following Actuarial Standards of Practice (ASOP) including:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications

I certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

I certify that the Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

On/Off Exchange Attestation

I certify that a single set of premium rates was submitted with this filing which is applicable for all plans offered both on and off the Exchange, and that this assures the same premium rate will be charged without regard to whether the plan is offered through the Exchange or whether the plan is offered directly from the Company or through an agent.

QHP Off Exchange Premium Tax Credit (PTC) Attestation

To notify consumers that coverage purchased outside of the Exchange is not eligible for premium tax credit assistance, the Company will include the following language in their marketing materials:

"DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace."

This disclaimer is located on page 1 of the Company's policy form.

The Part I Unified Rate Review Template does not demonstrate the process used by the Company to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Respectfully submitted,



Robert Macagnano, FSA, MAAA
Director
(973) 236-4082
Robert.Macagnano@us.pwc.com

Appendix A
Indiana University Health Plans, Inc.
Plan Design Summaries

Plan Name	Deductible	OOP Max	Coinsurance	PCP Visit	Specialist Visit	ER Visit	Inpatient Stay	Rx - Retail	Rx - Mail Order
IU Health Plans Gold Value	$750/$1,500	$6,000/$12,000	20% after deductible	$20 copay	$50 copay before deductible and 20% after deductible	$200 copay then deductible and 20% coinsurance	$500 copay then deductible and 20% coinsurance	$8/$20/20%/30%/30% (coinsurance applies after deductible)	$24/$60/20%/30%/30% (coinsurance applies after deductible)
IU Health Plans Silver HSA	$2,750/$5,500	$3,600/$7,200	10% after deductible	10% after deductible	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% after deductible	$15/$45/25%/35%/35% after deductible
IU Health Plans Silver Value	$2,500/$5,000	$6,350/$12,700	10% after deductible	$40 copay	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Silver Enhanced	$2,000/$4,000	$5,750/$11,500	20% after deductible	$30 copay	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Bronze HSA	$4,500/$9,000	$6,350/$12,700	20% after deductible	20% after deductible	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$10/$25/30%/40%/40% after deductible	$30/$75/30%/40%/40% after deductible
IU Health Plans Bronze Value	$6,000/$12,000	$6,350/$12,700	25% after deductible	$40 copay	25% after deductible	$350 copay then deductible and 25% coinsurance	$1,500 copay then deductible and 25% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)
IU Health Plans Bronze Enhanced	$5,000/$10,000	$6,350/$12,700	40% after deductible	$50 copay before deductible and then 40% after deductible	40% after deductible	$275 copay then deductible and 40% coinsurance	$750 copay then deductible and 40% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area

Member Distribution by Age	
Age Band	Membership Distribution
0-20	10.15%
21	1.09%
22	1.09%
23	1.09%
24	1.09%
25	1.09%
26	1.85%
27	1.85%
28	1.85%
29	1.85%
30	1.85%
31	1.85%
32	1.85%
33	1.85%
34	1.85%
35	1.68%
36	1.68%
37	1.68%
38	1.68%
39	1.68%
40	1.68%
41	1.68%
42	1.68%
43	1.68%
44	1.68%
45	2.12%
46	2.12%
47	2.12%
48	2.12%
49	2.12%
50	2.12%
51	2.12%
52	2.12%
53	2.12%
54	2.12%
55	2.98%
56	2.98%
57	2.98%
58	2.98%
59	2.98%
60	2.98%
61	2.98%
62	2.98%
63	2.98%
64	2.98%
65 and over	0.00%

Membership Distribution by Rating Area	
Rating Area	Membership Distribution
5	4.5%
7	30.9%
8	17.7%
10	9.0%
11	2.9%
13	29.9%
15	5.1%
Total	100.0%

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area
(continued)

		Silver					
Plan Name	**Gold**	**70**	**CSR 73**	**CSR 87**	**CSR 94**	**Bronze**	**Total**
IU Health Plans Gold Value	73						73
IU Health Plans Silver HSA		28	-	-	-		28
IU Health Plans Silver Value		168	152	284	69		673
IU Health Plans Silver Enhanced		84	76	142	35		337
IU Health Plans Bronze HSA						35	35
IU Health Plans Bronze Value						210	210
IU Health Plans Bronze Enhanced						105	105
Total	73	280	229	426	104	351	1,462

Appendix C
Indiana University Health Plans, Inc.
Rating Factors

Age-Based Tobacco Factors		
Age	Smoker	Non-smoker
0-20	1.000	1.000
21	1.050	1.000
22	1.050	1.000
23	1.050	1.000
24	1.050	1.000
25	1.050	1.000
26	1.050	1.000
27	1.050	1.000
28	1.050	1.000
29	1.050	1.000
30	1.050	1.000
31	1.070	1.000
32	1.090	1.000
33	1.110	1.000
34	1.130	1.000
35	1.150	1.000
36	1.170	1.000
37	1.190	1.000
38	1.210	1.000
39	1.230	1.000
40	1.250	1.000
41	1.270	1.000
42	1.290	1.000
43	1.310	1.000
44	1.330	1.000
45	1.350	1.000
46	1.370	1.000
47	1.390	1.000
48	1.410	1.000
49	1.430	1.000
50	1.450	1.000
51	1.470	1.000
52	1.490	1.000
53	1.490	1.000
54	1.473	1.000
55	1.410	1.000
56	1.348	1.000
57	1.290	1.000
58	1.234	1.000
59	1.208	1.000
60	1.158	1.000
61	1.118	1.000
62	1.094	1.000
63	1.065	1.000
64	1.048	1.000
65 and over	1.048	1.000

Federal Age Curve		
Age Band	Membership Distribution	Age Factor
0-20	10.15%	0.635
21	1.09%	1.000
22	1.09%	1.000
23	1.09%	1.000
24	1.09%	1.000
25	1.09%	1.004
26	1.85%	1.024
27	1.85%	1.048
28	1.85%	1.087
29	1.85%	1.119
30	1.85%	1.135
31	1.85%	1.159
32	1.85%	1.183
33	1.85%	1.198
34	1.85%	1.214
35	1.68%	1.222
36	1.68%	1.230
37	1.68%	1.238
38	1.68%	1.246
39	1.68%	1.262
40	1.68%	1.278
41	1.68%	1.302
42	1.68%	1.325
43	1.68%	1.357
44	1.68%	1.397
45	2.12%	1.444
46	2.12%	1.500
47	2.12%	1.563
48	2.12%	1.635
49	2.12%	1.706
50	2.12%	1.786
51	2.12%	1.865
52	2.12%	1.952
53	2.12%	2.040
54	2.12%	2.135
55	2.98%	2.230
56	2.98%	2.333
57	2.98%	2.437
58	2.98%	2.548
59	2.98%	2.603
60	2.98%	2.714
61	2.98%	2.810
62	2.98%	2.873
63	2.98%	2.952
64	2.98%	3.000
65 and over	0.00%	3.000
Weighted average age factor		1.685

Appendix C
Indiana University Health Plans, Inc.
Rating Factors
(continued)

Geographic Factors		
Rating Area	Membership Distribution	Rating Area Factor
5	4.5%	0.976
7	30.9%	0.976
8	17.7%	1.006
10	9.0%	1.060
11	2.9%	0.972
13	29.9%	1.010
15	5.1%	0.998
Total	**100.0%**	**1.000**

Plan Value Factors	
Plan Name	Pricing Value
IU Health Plans Gold Value	1.207
IU Health Plans Silver HSA	0.994
IU Health Plans Silver Value	1.000
IU Health Plans Silver Enhanced	1.009
IU Health Plans Bronze HSA	0.805
IU Health Plans Bronze Value	0.827
IU Health Plans Bronze Enhanced	0.837

Appendix D
Indiana University Health Plans, Inc.
Plan Adjusted Index Rate Development

Plan Name	Market adjusted index rate (a)	Actuarial value and cost sharing adjustment (b)	Adjustment for distribution and administrative costs (c)	Plan adjusted index rate (d) = (a) + (b) + (c)	Age calibration (e)	Geographic calibration (f)	Calibrated base rate (g) = (d) / [(e) x (f)]
IU Health Plans Gold Value	$ 623.78	$(116.90)	$110.16	$617.04	1.685	1.000	$366.17
IU Health Plans Silver HSA	$ 623.78	$(207.39)	$91.72	$508.12	1.685	1.000	$301.54
IU Health Plans Silver Value	$ 623.78	$(204.67)	$92.27	$511.38	1.685	1.000	$303.47
IU Health Plans Silver Enhanced	$ 623.78	$(200.98)	$93.02	$515.82	1.685	1.000	$306.10
IU Health Plans Bronze HSA	$ 623.78	$(287.55)	$75.44	$411.67	1.685	1.000	$244.30
IU Health Plans Bronze Value	$ 623.78	$(278.22)	$77.32	$422.88	1.685	1.000	$250.95
IU Health Plans Bronze Enhanced	$ 623.78	$(273.87)	$78.20	$428.11	1.685	1.000	$254.06

Appendix E
Indiana University Health Plans, Inc.
Rating Examples

Selected Plan:	IU Health Plans Silver Value
Rating Area:	Rating Area 11

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$303.47	0.972	2.230	1.410	$927.59
Spouse	40	Non-Smoker	$303.47	0.972	1.278	1.000	$377.02
Child 1	18	Non-Smoker	$303.47	0.972	0.635	1.000	$187.33
Child 2	15	Smoker	$303.47	0.972	0.635	1.000	$187.33
Child 3	13	Non-Smoker	$303.47	0.972	0.635	1.000	$187.33
Child 4	10	Non-Smoker	$303.47	0.972	0.635	1.000	$0.00
Total Premium							$1,866.80

Selected Plan:	IU Health Plans Gold Value
Rating Area:	Rating Area 7

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$366.17	0.976	2.230	1.410	$1,123.52
Spouse	40	Non-Smoker	$366.17	0.976	1.278	1.000	$456.65
Child 1	18	Non-Smoker	$366.17	0.976	0.635	1.000	$226.90
Child 2	15	Smoker	$366.17	0.976	0.635	1.000	$226.90
Child 3	13	Non-Smoker	$366.17	0.976	0.635	1.000	$226.90
Child 4	10	Non-Smoker	$366.17	0.976	0.635	1.000	$0.00
Total Premium							$2,260.86

IU Health Plans Gold Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☑		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.80	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.4%
Metal Tier:	Gold

IU Health Plans Silver HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.0%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.5%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$800.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,200.00			
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.2%
Metal Tier:	Gold

IU Health Plans Silver HSA - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$400.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.1%
Metal Tier:	Platinum

IU Health Plans Silver Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
		$750.00			
		90.00%			
		$1,500.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.4%
Metal Tier:	Gold

IU Health Plans Silver Value - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
		Deductible ($): $200.00			
		Coinsurance (%, Insurer's Cost Share): 90.00%			
		OOP Maximum ($): $600.00			
		OOP Maximum if Separate ($):			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

IU Health Plans Silver Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$2,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$5,750.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
		$2,000.00			
		80.00%			
		$4,500.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.7%
Metal Tier:	Gold

IU Health Plans Silver Enhanced - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$150.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$650.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

IU Health Plans Bronze HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.6%
Metal Tier:	Bronze

IU Health Plans Bronze Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$350.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze

IU Health Plans Bronze Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$275.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☑		$50.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.8%
Metal Tier:	Bronze

Appendix G
Indiana University Health Plans, Inc.
Capital, Surplus, and RBC Information

Annual Statement for the year 2013 of the Indiana University Health Plans, Inc.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)				
2. Stocks (Schedule D):				
2.1 Preferred stocks				
2.2 Common stocks				
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens				
3.2 Other than first liens				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ encumbrances)				
4.2 Properties held for the production of income (less $ encumbrances)				
4.3 Properties held for sale (less $ encumbrances)				
5. Cash ($ 6,645,144, Schedule E - Part 1), cash equivalents ($, Schedule E - Part 2), and short-term investments ($, Schedule DA)	6,645,144		6,645,144	8,006,798
6. Contract loans (including $ premium notes)				
7. Derivatives (Schedule DB)				
8. Other invested assets (Schedule BA)				
9. Receivables for securities				
10. Securities lending reinvested collateral assets (Schedule DL)				
11. Aggregate write-ins for invested assets				
12. Subtotals, cash and invested assets (Lines 1 to 11)	6,645,144		6,645,144	8,006,798
13. Title plants less $ charged off (for Title insurers only)				
14. Investment income due and accrued	1,068		1,068	2,137
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	231,209	66,791	164,418	201,607
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ earned but unbilled premiums)				
15.3 Accrued retrospective premiums				
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers				
16.2 Funds held by or deposited with reinsured companies				
16.3 Other amounts receivable under reinsurance contracts				
17. Amounts receivable relating to uninsured plans				
18.1 Current federal and foreign income tax recoverable and interest thereon				
18.2 Net deferred tax asset				
19. Guaranty funds receivable or on deposit				
20. Electronic data processing equipment and software				
21. Furniture and equipment, including health care delivery assets ($)				
22. Net adjustment in assets and liabilities due to foreign exchange rates				
23. Receivables from parent, subsidiaries and affiliates	332,038		332,038	714,499
24. Health care ($ 449,493) and other amounts receivable	1,838,476	915,716	922,760	616,348
25. Aggregate write-ins for other than invested assets	1,110,648	156,922	953,726	510,111
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	10,158,583	1,139,429	9,019,154	10,051,500
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28. Total (Lines 26 and 27)	10,158,583	1,139,429	9,019,154	10,051,500

DETAILS OF WRITE-IN LINES				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	NONE			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501. Estimated Medicare Settlement Receivable	953,726		953,726	510,111
2502. Prepaid General and Administrative Expenses	156,922	156,922		
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page				
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	1,110,648	156,922	953,726	510,111

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ 0 reinsurance ceded)				
2.	Accrued medical incentive pool and bonus amounts				
3.	Unpaid claims adjustment expenses				
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Services Act	29,399		29,399	105,075
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	294,066		294,066	229,823
9.	General expenses due or accrued	818,192		818,192	1,431,649
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))				
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others				
13.	Remittances and items not allocated				
14.	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)				
15.	Amounts due to parent, subsidiaries and affiliates				12,550
16.	Derivatives				
17.	Payable for securities				
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified $ (0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans				
23.	Aggregate write-ins for other liabilities (including $ 0 current)	595,407		595,407	871,800
24.	Total liabilities (Lines 1 to 23)	1,737,064		1,737,064	2,650,897
25.	Aggregate write-ins for special surplus funds	XXX	XXX		
26.	Common capital stock	XXX	XXX	1,000	1,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	27,499,000	27,999,000
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	(20,217,910)	(20,599,397)
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX		
	32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	7,282,090	7,400,603
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	9,019,154	10,051,500

	DETAILS OF WRITE-IN LINES				
2301.	Estimated Medicare Settlement Liability	338,139		338,139	667,855
2302.	Other Amounts Payable	257,268		257,268	203,945
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	595,407		595,407	871,800
2501.		XXX	XXX		
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

NONE

NONE

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL - XR025

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		7,282,090	
(2)	Company Action Level=200% of Authorized Control Level	CAL	4,146,860	
(3)	Regulatory Action Level=150% of Authorized Control Level	RAL	3,110,145	
(4)	Authorized Control Level=100% of Authorized Control Level	ACL	2,073,430	
(5)	Mandatory Control Level=70% of Authorized Control Level	MCL	1,451,401	
(6)	Level of Action, if Any		NONE	

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	7,282,090
Authorized Control Level Risk-Based Capital on Line 15 of the Five Year Historical Data Page	2,073,430

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	98,250,957	
(8)	Underwriting Deductions	Page 4, Line 23	97,709,883	
(9)	Combined Ratio	Line (8)/Line(7)	99.400	
(10)	RBC Ratio	Line(1)/Line(4)	351.200	
(11)	Trend Test Result	If Line(10) is between 200% and 300% and Line (9) > 105%, then "Yes", otherwise "No"		**No**
(12)	Level of Action, if any, including Trend Test		NONE	

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Supporting Document Schedules

Bypassed - Item:	10 Individual Checklist (Accident & Health)
Bypass Reason:	Not Applicable
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	12 Individual HMO Checklist (Accident & Health)
Bypass Reason:	Not Applicable
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	20(C) Out of State Association/Trust Products Checklist (Accident & Health)
Bypass Reason:	Not Applicable
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	12(A) Individual HMO Checklist (Accident & Health)
Comments:	IU Health plans is submitting checklist 12a for Adult & Child
Attachment(s):	IU Health Plans - Checklist - ADULT.PDF IU Health Plans - Checklist - Child Only.PDF
Item Status:	
Status Date:	

Bypassed - Item:	4.1 Individual New Rate/Form Requirements (Accident & Health)
Bypass Reason:	Not Applicable
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0 Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	Not Applicable
Attachment(s):	
Item Status:	

Status Date:	

Satisfied - Item:	4.1(A) QHP Individual New Rate/Form Requirements (Accident & Health)
Comments:	Complied
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0(A) QHP Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	Not applicable to this filing
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	4.1(B) EHB Individual New Rate/Form Requirements (Accident & Health)
Comments:	Complied
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0(B) EHB Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	New filing, Not applicable
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	09 SERFF Data Field Guide (Accident & Health)
Comments:	Resubmitted as part of the response to the July 29, 2014 objection letter
Attachment(s):	SERFF Data Field Guide - IUHP_8.1.2014.xls
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	Not applicable to initial submission
Attachment(s):	
Item Status:	
Status Date:	

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Bypassed - Item:	04 Major Medical Experience Workbook (Accident & Health)
Bypass Reason:	new filing, uses manual rates
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	FINAL IUHP 2015 Individual Actuarial Memorandum - Medicaid Spend Down.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	Revised in response to IDOI Letter of July 29, 2014
Attachment(s):	IU_Health Plans_plan_management_data_templates_unified_8.1.2014.xml
Item Status:	
Status Date:	

Bypassed - Item:	03 PPACA Uniform Compliance Summary
Bypass Reason:	Per Indiana instructions included in the IDOI Checklist
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - Flesch Readability Certificate-Adult
Comments:	
Attachment(s):	IU Health Plans - Flesch Readability Certificate - Adult.pdf
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - Flesch Readability Certificate-Child
Comments:	
Attachment(s):	IU Health Plans - Flesch Readability Certificate - Child.pdf
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - Statement of Variability - ADULT

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Comments:	
Attachment(s):	IU Health Plans - Statement of Variability - ADULT.pdf
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - Statement of Variability - CHILD
Comments:	
Attachment(s):	IU Health Plans - Statement of Variability - CHILD.pdf
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - EHB Crosswalk and Certification Tool - ADULT
Comments:	
Attachment(s):	IU Health Plans - EHB Crosswalk and Certification Tool - ADULT.PDF
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - EHB Crosswalk and Certification Tool - CHILD
Comments:	
Attachment(s):	IU Health Plans - EHB Crosswalk and Certification Tool - CHILD.PDF
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - Variable Contract - ADULT _redline
Comments:	Redline of revised adult contract
Attachment(s):	IU Health Plans - Variable Contract - ADULT _redline.pdf
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - Variable Contract - CHILD _redline
Comments:	REdline of revised child contract
Attachment(s):	IU Health Plans - Variable Contract - CHILD _redline.pdf
Item Status:	
Status Date:	

Satisfied - Item:	IUHP Responses to IDOI Objection Letter Dated 5 27 2014 - 2015 Individual Rate Filing
Comments:	

SERFF Tracking #:	*IUHP-129535085*	***State Tracking #:***	*13164.1-INDIV-POLICY (01/2015)*	***Company Tracking #:***	

State:	*Indiana*	***Filing Company:***	*IU Health Plans*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*IU Health Plans Individual Product*		
Project Name/Number:	*Marketplace Ind 2015/*		

Attachment(s):	IUHP Responses to IDOI Objection Letter Dated 5 27 2014 - 2015 Individual Rate Filing.pdf
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - Application - ADULT_CHILD _marked IDOI Objections 6_6_14_
Comments:	Marked up version of Application responding to IDOI request of 6/6/2014
Attachment(s):	IU Health Plans - Application - ADULT_CHILD _marked IDOI Objections 6_6_14_.pdf
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans - Adult Policy Comparison to Adult and Child Only Combined Policy_06122014
Comments:	Adult policy comparison version of Adult to combined Adult & Child Only poicy
Attachment(s):	IU Health Plans - Adult Policy Comparison to Adult and Child Only Combined Policy_06122014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	IUHP Responses to IDOI Objection Letter Dated 7.7.2014 - 2015 Individual Rate Filing (Q1 to Q4).pdf
Comments:	Responses to Questions 1-4 July 7 objection letter
Attachment(s):	IUHP Responses to IDOI Objection Letter Dated 7.7.2014 - 2015 Individual Rate Filing (Q1 to Q4).pdf
Item Status:	
Status Date:	

Satisfied - Item:	IU Health Plans Formulary Response to Objection Letter 07072014.pdf
Comments:	These are the responses and explanation to the request for formulary information
Attachment(s):	IU Health Plans HIX IN Count by Tiers for IDOI.xlsx IU Health Plans IN SERFF Category & Class for IDOI.xlsx IU Health Plans Formulary Response to Objection Letter 07072014.pdf
Item Status:	
Status Date:	

Attachment SERFF Data Field Guide - IUHP_8.1.2014.xls is not a PDF document and cannot be reproduced here.

Attachment IU_Health Plans_plan_management_data_templates_unified_8.1.2014.xml is not a PDF document and cannot be reproduced here.

Attachment IU Health Plans HIX IN Count by Tiers for IDOI.xlsx is not a PDF document and cannot be reproduced here.

Attachment IU Health Plans IN SERFF Category & Class for IDOI.xlsx is not a PDF document and cannot be reproduced here.

Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

12(A) Non-Grandfathered
HMO Individual Major Medical & Dental

This checklist must be submitted with any form filings for HMO Individual Major Medical or HMO Individual Dental plans that are not Grandfathered. This checklist should also be used for HMO Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name Indiana University Health Plans, Inc **NAIC #** 13164

Form number(s) 13164.1-Indiv-Policy-Adult (01/2015) **Filing date** 05/09/2014

Product Type:	☑	**Major Medical**	☐	**Pediatric Stand-Alone Dental**
Exchange Participation:	☑	**Off-Exchange**	☑	**On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

A. General Filing Requirements 2
B. Required Provisions..... 4
C.HMO Individual A&H Policies *must provide* 7
D. General Regulatory Issues..... 9
E. HMO Individual A&H must cover 10
F. ACA Must Provide..... 11
G. Specific Requirements for Qualified Health Plans 26
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan 28

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.	X	
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm	X	
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.	X	
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.	N/A	
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. *Please acknowledge.*	X	
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.	X	
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-13-7-3(a)(1)	**THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION**	Page i	
IC 27-13-7-3(a)(2)	**ELIGIBILITY REQUIREMENTS**	Page 9	
IC 27-13-7-3(a)(3)	**BENEFITS AND SERVICES WITHIN THE SERVICE AREA**	Article 4 (starts at Page 19)	
IC 27-13-7-3(a)(4) IC 27-13-36-9	**EMERGENCY CARE BENEFITS AND SERVICES**	Page 24	
IC 27-13-7-3(a)(5)	**ANY OUT-OF-AREA BENEFITS AND SERVICES**	Page 24; 63	
IC 27-13-7-3(a)(6)	**COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS**	Page 17 & Schedule of Benefits	
IC 27-13-7-3(a)(7)	**LIMITATIONS AND EXCLUSIONS**	Page 54	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(8)	**ENROLLEE TERMINATION PROVISIONS**	Page 79	
IC 27-13-7-3(a)(9)	**ANY ENROLLEE REINSTATEMENT PROVISIONS**	Page 82	
IC 27-13-7-3(a)(10)	**CLAIMS PROCEDURES**	Page 72	
IC 27-13-36.2	**CLEAN CLAIMS**	Page 73	
IC 27-13-7-3(a)(11)	**ENROLLEE GRIEVANCE PROCEDURES**	Page 68-71; 83-85	
IC 27-13-7-3(a)(12)	**CONTINUATION OF COVERAGE PROVISIONS**	Page 81	
IC 27-13-7-3(a)(13)	**CONVERSION PROVISIONS**	N/A - indiv policy	
IC 27-13-7-3(a)(14)	**EXTENSION OF BENEFIT PROVISIONS**	N/A - indiv policy; pg 81 continua	
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	**COORDINATION OF BENEFIT PROVISIONS. NOT APPLICABLE FOR LIMITED SERVICE HEALTH MAINTENANCE ORGANIZATIONS**	Page 74-78	
IC 27-13-7-3(a)(16)	**ANY SUBROGATION PROVISIONS**	Page 77; 88	
IC 27-13-7-3(a)(17)	**A DESCRIPTION OF THE SERVICE AREA**	Page 7	
IC 27-13-7-3(a)(18)	**THE ENTIRE CONTRACT PROVISIONS**	Page 86	
IC 27-13-7-3(a)(19)	**THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT**	Page 6	
IC 27-13-7-3(a)(20)	**ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER**	Page 80	
IC 27-13-7-3(a)(21)	**RIGHT OF RENEWAL PROVISIONS**	Page 79	
IC 27-13-7-3(a)(22)	**PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER**	Page 82	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(23)	**GRACE PERIOD PROVISIONS** For On-Exchange products see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.	Page 16-17	
IC 27-13-7-3(a)(24)	**A PROVISION ON CONFORMITY WITH STATE LAW**	Page 89	
IC 27-13-7-3(a)(25)	**GUARANTEED RENEWABILITY:** A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))	Page 79	
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	**DEPENDENT AGE 26** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.	Page 2	
IC 27-13-7-4	**FREE LOOK:** 10 day "free look" provision	Page i	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.	Page 68-71; 83-85	
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance	Page 71, 85	
C.HMO Individual A&H Policies *must provide*			
IC 27-8-5-15.6(e)	**SUBSTANCE ABUSE PARITY**—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits	Page 20	
IC 27-8-5-19(c)(17)	**HANDICAPPED CHILDREN** beyond the age of maturity. (with 120 days notice to the company)	Page 2 (31 day notice as applicable in the individual market)	
IC 27-8-5-21	**ADOPTED CHILDREN**	Page 12-13	
IC 27-8-5.6-2(b)	**NEWBORNS**	Page 12	
IC 27-8-14.5	**DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION**	Page 22-23	
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**	Page 61	
IC 27-8-24	**MINIMUM MATERNITY STAYS**	Page 28	
IC 27-8-24.3	**VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE**	Page 88	
IC 27-8-24-4	**INFANT SCREENING TESTS REQUIRED BY IC 16-41-17-2**	Page 29	
IC 27-8-26	Individuals without regard to **GENETIC TESTING**	Page 88	
IC 27-13-7-13	**CONTINUATION OF COVERAGE STATEMENT**	Page 81	
IC 27-13-7-15	**DENTAL ANESTHESIA/HOSPITALIZATION**	Page 22	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14	**BREAST RECONSTRUCTION AND PROSTHESIS FOLLOWING MASTECTOMY:-**Regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727	Page 38-39	
IC 27-13-7-14.8	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136	Page 20	
IC 27-13-37.5-2	**PRESCRIPTION DRUG:** Can't require use of specific mail order pharmacy for coverage	The Contract has no such requirement	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-38-1	**PRESCRIPTION DRUG:** Allows formularies but requires process for obtaining non-formulary drug	Page 51	
Bulletin 172	**CHEMOTHERAPY PARITY**	Page 48	
760 IAC 1-39-7	**AIDS, HIV AND RELATED CONDITIONS**	The Contract has no such exclus	
COBRA/ERISA	**OPPORTUNITY FOR COBRA COVERAGE IF EMPLOYER HAS 20 OR MORE EMPLOYEES**	N/A - individual coverage	
D. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1.5 and 27-13-7-2, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage the misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will be reviewed.**		
IC 27-13-7-2	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.	Application has no such questions	
IC 27-13-7-2	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.	The Contract has no such provisions	
IC 27-13-7-2	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.	The Contract has no endorsements	
IC 27-13-7-2	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.	The Contract has no endorsements	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.	The Contract has no such provisions	
IC 27-13-7-2	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.	The Contract has no such fees; free look at page i	
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.	The Contract has no such provisions	
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.	The Contract has no such provisions	
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.	N/A	
E. HMO Individual A&H must cover	Due to the EHB benchmark requirements, the following must be covered.		
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDERS (PREVIOUSLY PDD):** As per Bulletins 136 and 179, "Coverage for services provided as prescribed by the insured's treating physician in accordance with treatment plan." Autism Spectrum Disorders includes Asperger's Syndrome and Autism.	Page 34-35	
IC 27-13-7-15.3	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)	Page 37	
IC 27-13-7-16	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk)	page 38	
IC 27-13-7-17 IC 27-8-14.8	**COLORECTAL CANCER SCREENING**	Page 37	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-37-4	**POINT-OF SERVICE PRODUCT**	N/A for exchange products	
IC 27-13-7-18	**INHERITED METABOLIC DISEASE**	Page 30	
F. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302	Page 19	
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302	Page 24	
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302	Page 26	
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302	Page 27-28	
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302	Page 20	
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302	Page 45-51	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302	Page 40	
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302	Page 23	
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130	Page 36-38	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302	Page 51	
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please Acknowledge* PHSA §2715 75 Fed Reg 41760	X	
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please Acknowledge* PHSA §2728 45 CFR §147.145	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)	X	
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please Acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126	X	
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please Acknowledge* 45 CFR §156.122(a)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please Acknowledge* PHSA §2715	X	
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please Acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(e)	X	
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(a)	X	
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b) 45 CFR §155.410	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(c)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(d)	X	
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(a)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)	X	
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(c)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(d)	X	
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)	N/A - individual contract	
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)	X	
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)	Page 16-17	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)	Page 17	
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)	Contract does not cover non-Therapeutic abortion	
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)	Contract does not cover non-Therapeutic abortion	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)	Page 16	
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify the policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330	X	
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.	N/A	

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is

relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature: Constance D Brown

Printed Name: Constance D Brown

Title: CFO/COO

Company: In Hea lth Plans

Date: 5/9/2014

Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

12(A) Non-Grandfathered
HMO Individual Major Medical & Dental

This checklist must be submitted with any form filings for HMO Individual Major Medical or HMO Individual Dental plans that are not Grandfathered. This checklist should also be used for HMO Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name Indiana University Health Plans, Inc **NAIC #** 13164

Form number(s) 13164.1-Indiv-Policy-Child **Filing date** 05/09/2014

Product Type:	☑	**Major Medical**	☐	**Pediatric Stand-Alone Dental**
Exchange Participation:	☑	**Off-Exchange**	☑	**On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

A. General Filing Requirements 2
B. Required Provisions..... 4
C.HMO Individual A&H Policies *must provide* 7
D. General Regulatory Issues..... 9
E. HMO Individual A&H must cover 10
F. ACA Must Provide..... 11
G. Specific Requirements for Qualified Health Plans 26
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan 28

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.	X	
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm	X	
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.	X	
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.	N/A	
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. *Please acknowledge.*	X	
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.	X	
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-13-7-3(a)(1)	**THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION**	Page i	
IC 27-13-7-3(a)(2)	**ELIGIBILITY REQUIREMENTS**	Page 9	
IC 27-13-7-3(a)(3)	**BENEFITS AND SERVICES WITHIN THE SERVICE AREA**	Article 4 (starts at Pg 19)	
IC 27-13-7-3(a)(4) IC 27-13-36-9	**EMERGENCY CARE BENEFITS AND SERVICES**	Page 24	
IC 27-13-7-3(a)(5)	**ANY OUT-OF-AREA BENEFITS AND SERVICES**	Page 24, 63	
IC 27-13-7-3(a)(6)	**COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS**	Page 17 & Schedule of Benefits	
IC 27-13-7-3(a)(7)	**LIMITATIONS AND EXCLUSIONS**	Page 54	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(8)	**ENROLLEE TERMINATION PROVISIONS**	Page 79	
IC 27-13-7-3(a)(9)	**ANY ENROLLEE REINSTATEMENT PROVISIONS**	Page 82	
IC 27-13-7-3(a)(10)	**CLAIMS PROCEDURES**	Page 72	
IC 27-13-36.2	**CLEAN CLAIMS**	Page 73	
IC 27-13-7-3(a)(11)	**ENROLLEE GRIEVANCE PROCEDURES**	Page 68-71; 83-85	
IC 27-13-7-3(a)(12)	**CONTINUATION OF COVERAGE PROVISIONS**	Page 81	
IC 27-13-7-3(a)(13)	**CONVERSION PROVISIONS**	N/A - Individual policy	
IC 27-13-7-3(a)(14)	**EXTENSION OF BENEFIT PROVISIONS**	N/A - Indiv policy, see pg 81 re: c	
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	**COORDINATION OF BENEFIT PROVISIONS. NOT APPLICABLE FOR LIMITED SERVICE HEALTH MAINTENANCE ORGANIZATIONS**	Page 74-78	
IC 27-13-7-3(a)(16)	**ANY SUBROGATION PROVISIONS**	Page 77; 88	
IC 27-13-7-3(a)(17)	**A DESCRIPTION OF THE SERVICE AREA**	Page 7	
IC 27-13-7-3(a)(18)	**THE ENTIRE CONTRACT PROVISIONS**	Page 86	
IC 27-13-7-3(a)(19)	**THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT**	Page 6	
IC 27-13-7-3(a)(20)	**ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER**	Page 80	
IC 27-13-7-3(a)(21)	**RIGHT OF RENEWAL PROVISIONS**	Page 79	
IC 27-13-7-3(a)(22)	**PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER**	Page 82	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(23)	**GRACE PERIOD PROVISIONS** For On-Exchange products see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.	Page 16-17	
IC 27-13-7-3(a)(24)	**A PROVISION ON CONFORMITY WITH STATE LAW**	Page 89	
IC 27-13-7-3(a)(25)	**GUARANTEED RENEWABILITY:** A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))	Page 79	
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	**DEPENDENT AGE 26** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.	N/A - child only policy, coverage til age 21	
IC 27-13-7-4	**FREE LOOK:** 10 day "free look" provision	Page i	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.	Page 68-70; 83-85	
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance	Page 71; 85	
C.HMO Individual A&H Policies *must provide*			
IC 27-8-5-15.6(e)	**SUBSTANCE ABUSE PARITY**—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits	Page 2; 20	
IC 27-8-5-19(c)(17)	**HANDICAPPED CHILDREN** beyond the age of maturity. (with 120 days notice to the company)	N/A - child only policy, coverage til age 21	
IC 27-8-5-21	**ADOPTED CHILDREN**	Page 13	
IC 27-8-5.6-2(b)	**NEWBORNS**	Page 12	
IC 27-8-14.5	**DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION**	Page 22-23	
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**	Page 61	
IC 27-8-24	**MINIMUM MATERNITY STAYS**	Page 27-28	
IC 27-8-24.3	**VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE**	Page 88	
IC 27-8-24-4	**INFANT SCREENING TESTS REQUIRED BY IC 16-41-17-2**	Page 29	
IC 27-8-26	Individuals without regard to **GENETIC TESTING**	Page 88	
IC 27-13-7-13	**CONTINUATION OF COVERAGE STATEMENT**	Page 81	
IC 27-13-7-15	**DENTAL ANESTHESIA/HOSPITALIZATION**	Page 22	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14	**BREAST RECONSTRUCTION AND PROSTHESIS FOLLOWING MASTECTOMY:-**Regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727	Page 38-39	
IC 27-13-7-14.8	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136	Page 2; 20	
IC 27-13-37.5-2	**PRESCRIPTION DRUG:** Can't require use of specific mail order pharmacy for coverage	The Contract has no such provision	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-38-1	**PRESCRIPTION DRUG:** Allows formularies but requires process for obtaining non-formulary drug	Page 51	
Bulletin 172	**CHEMOTHERAPY PARITY**	Page 48	
760 IAC 1-39-7	**AIDS, HIV AND RELATED CONDITIONS**	No such exclusions	
COBRA/ERISA	**OPPORTUNITY FOR COBRA COVERAGE IF EMPLOYER HAS 20 OR MORE EMPLOYEES**	N/A - individual contract	
D. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1.5 and 27-13-7-2, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage the misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will be reviewed.**		
IC 27-13-7-2	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.	The application has no such questions	
IC 27-13-7-2	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.	The Contract has no such provisions	
IC 27-13-7-2	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.	The Contract has no endorsements	
IC 27-13-7-2	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.	The Contract has no endorsements	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.	The Contract has no such provisions	
IC 27-13-7-2	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.	The Contract has no such fees; free look - page i	
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.	The Contract has no such provision	
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.	The Contract has no such provision	
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.	N/A	
E. HMO Individual A&H must cover	Due to the EHB benchmark requirements, the following must be covered.		
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDERS (PREVIOUSLY PDD):** As per Bulletins 136 and 179, "Coverage for services provided as prescribed by the insured's treating physician in accordance with treatment plan." Autism Spectrum Disorders includes Asperger's Syndrome and Autism.	Page 34-35	
IC 27-13-7-15.3	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)	Page 37	
IC 27-13-7-16	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk)	Page 38	
IC 27-13-7-17 IC 27-8-14.8	**COLORECTAL CANCER SCREENING**	Page 37	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-37-4	**POINT-OF SERVICE PRODUCT**	N/A for exchange product	
IC 27-13-7-18	**INHERITED METABOLIC DISEASE**	Page 30	
F. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302	Page 19	
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302	Page 24	
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302	Page 26	
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302	Page 27-28	
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302	Page 20	
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302	Page 45-51	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302	Page 40	
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302	Page 23	
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130	Page 36-38	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302	Page 51 (vision) N/A for dental due to availability of stand alone dental plans	
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please Acknowledge* PHSA §2715 75 Fed Reg 41760	X	
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please Acknowledge* PHSA §2728 45 CFR §147.145	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)	X	
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please Acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126	X	
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please Acknowledge* 45 CFR §156.122(a)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please Acknowledge* PHSA §2715	X	
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please Acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(e)	X	
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(a)	X	
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b) 45 CFR §155.410	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(c)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(d)	X	
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(a)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)	X	
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(c)	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(d)	X	
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)	N/A - individual contract	
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)	Page 51	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138	X	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155	N/A	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)	x	
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)	Page 16-17	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)	Page 17	
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)	Contract does not cover non-therapeutic abortions	
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)	Contract does not cover non-therapeutic abortions	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)	Page 16	
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify the policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330	X	
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.	N/A	

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is

relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature: Constance D Brown

Printed Name: Constance D Brown

Title: CFO

Company: In Health Plans

Date: 5/9/2014

Actuarial Memorandum

Indiana University Health Plans, Inc.

Individual Health Rate Filing

Effective January 1, 2015 through December 31, 2015

Form: 13164.1-Indiv-Policy-Adult (01/2015)

13164.1-Indiv-Policy-Child (01/2015)

Submitted: May 28, 2014

TABLE OF CONTENTS

1) General Information 3
2) Proposed Rate Increase(s) 4
3) Experience Period Premium and Claims 4
4) Benefit Categories 5
5) Projection Factors 5
6) Credibility Manual Rate Development 5
7) Credibility of Experience 7
8) Paid to Allowed Ratio 7
9) Risk Adjustment and Reinsurance 8
10) Non-Benefit Expenses and Profit & Risk 8
11) Projected Loss Ratio 9
12) Single Risk Pool 10
13) Index Rate 10
14) Market Adjusted Index Rate 10
15) Plan Adjusted Index Rates 11
16) Calibration 12
17) Consumer Adjusted Premium Rate Development 13
18) AV Metal Values 13
19) AV Pricing Values 14
20) Membership Projections 14
21) Terminated Products 14
22) Plan Type 14
23) Warning Alerts 14
24) Company Financial Position 14
25) Reliance 15
26) Actuarial Certification 15

1) General Information

Overview

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template (URRT), which supports compliance with the market rating rules and reasonableness of applicable rate increases.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with State of Indiana statutes and provisions of the Affordable Care Act (ACA). This memorandum documents the development of the Individual rates for Indiana University Health Plans, Inc. (IUHP). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This information may not be appropriate for other purposes.

This information is intended for use by the State of Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of IUHP's Individual rate filing. However, we recognize that this certification may become a public document. PwC makes no representations or warranties regarding the contents of this memorandum to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for IUHP by PwC that would result in the creation of any duty or liability under any theory of law by PwC or its employees to third parties.

These results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

Company Identifying Information

- Company Legal Name: Indiana University Health Plans, Inc.
- State: The State of Indiana has regulatory authority over these policies
- HIOS Issuer ID: 33380
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: Eric Neuville, Vice President Product Development and Innovation
- Primary Contact Telephone Number: (317) 963-1835
- Primary Contact Email Address: eneuville@iuhealth.org

Certifying Actuary Contact Information

- Primary Contact Name: Robert Macagnano, PwC
- Primary Contact Telephone Number: (973) 236-4082
- Primary Contact Email Address: robert.macagnano@us.pwc.com

Benefit Summary

IUHP will be offering three Bronze, three Silver, and one Gold HMO products. A summary of the major provisions of each plan are provided in Appendix A.

Premium Guarantee Provision

Premiums are guaranteed not to change through December 31, 2015.

Renewability

The policy is renewable by paying the applicable renewal premiums unless the policyholder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability

The rates will apply to new business. Subsequent renewal business will be subject to rates filed for our 2016 rate development.

Premium Modalization

Premiums will be collected only on a monthly basis.

Trend Assumption

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2) Proposed Rate Increase(s)

This is a new filing therefore no rate increase assumption is included in this filing. Subsequent rate increases beginning with effective dates of January 1, 2016 will be filed in the future.

3) Experience Period Premium and Claims

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

4) Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.

Capitation: Includes capitated services for pediatric vision benefits.

Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

5) Projection Factors

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6) Credibility Manual Rate Development

The PwC Rating Model was used as the basis to develop the manual rates. Our model was developed using two primary sources:

- Commercial Truven Health MarketScan® Research Databases for U.S. members and providers. The database contains full enrollment and claims information with standard medical coding which allows for cost and utilization information by service category (inpatient, outpatient hospital, hospice, home health, professional, prescription drugs, etc.). The database consists of the experience from 53 million Commercial eligible participants. The data can be extracted down to the member's state and MSA level. For the Indiana Commercial market, there were approximately 1.5 million exposed life years' worth of data crossing all ages, genders and employment statuses (active, COBRA, disabled and retired). Nationwide, the databases have over 100 unique data contributors so it is not skewed to any one payer.
- OptumInsight (Optum) Comprehensive Pricing Model® provides benchmark data and pricing capabilities for Commercial health plans. It factors in health plan features such as deductibles, copays, out-of-pocket maximums, covered services, etc. The model uses normative data and benefit details to arrive at an allowed cost per member per month. The

normative benchmarking utilization metrics within the model are developed from Optum's database of Commercial (under 65) health plan experience of approximately 20 million life years. The model experience was adjusted to reflect the Indiana marketplace.

Since both the Truven and Optum data sources represent fully-completed calendar year 2012 claims, allowed costs were trended to the midpoint of calendar year 2015 using an annual trend rate of 7.4%.

The allowed costs component of the manual rates was increased by 2% to account for expected changes in covered benefits due to the Essential Health Benefits (EHB) requirements. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- State mandated benefits included in the EHB that previously only applied to group coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

In our May 9, 2014 filing, we noted that the Indiana Department of Insurance (IDOI) was expected to provide additional information pertaining to the Medicaid Spend-Down population. IUHP also reserved the right to revise their initial filing to reflect any additional data. Subsequent to IUHP's May 9, 2014 filing, the IDOI released additional SFY 2013 information pertaining to the Medicaid Spend-Down population which included the following:

- Summary of unique individuals, Medicaid allowed, Medicaid paid, and billed charges by age band, gender, and FPL % category
- Summary of the Medicaid allowed, Medicaid paid, and Billed charges for each unique individual
- Summary of unique individuals, Medicaid allowed, Medicaid paid, and billed charges by county

The manual rates were increased by 5.2% to reflect the entrance of approximately 7,000 Medicaid Spend-Down beneficiaries into the Indiana Health Insurance Exchange. This adjustment was based on the assumption that IUHP's penetration of the Medicaid Spend-Down population would be similar to their assumed penetration of the general population for the counties included in IUHP's proposed service area.

There will also be new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services. Pent up demand has been shown to increase costs in the first year of enrollment for those

previously uninsured. Based on analysis of programs serving a similar population, it appears that the claims are higher in the first six to 12 months that an individual is newly insured. After this initial period, the claims experience tends to revert to the average level for the market. The total effect is uncertain and may be offset by some new enrollees having reduced utilization as they may not fully understand new or increased coverage. Therefore, we have included an adjustment within our manual rate development for pent up demand of 5.0%.

The following adjustments were made to calibrate the pricing model to the expected population:

- Rating region
- Expected demographics
- Expected morbidity
- Contractual Agreements with healthcare providers
- Expected utilization management savings
- Benefit plan designs

Some benefits will be reimbursed under a capitation arrangement. The provider reimbursement adjustment to the pricing model was developed to account for the cost of capitated services.

The manual rates were also adjusted upward by a factor of 1.005 to account for the likelihood that some enrollees may not pay their premiums due during the first month of the 90-day grace period. This was calculated assuming a 15% rate of non-payment on one-twelfth of the annual premium due for 80% of the Individual population (those eligible for Advance Payments of a Premium Tax Credit). The amount of premium at risk is only on the portion that IUHP does not receive via direct subsidy, estimated to be 50% (0.15 x 1/12 x 0.80 x 0.50 = 0.005). The 15% represents our assumption regarding the small portion of enrollees that we believe will knowingly take advantage of the grace period provision. The 80% represents the portion of enrollees in the 2015 Individual marketplace that we assume will be eligible for premium subsidies based on income level. On May 1, 2014 the Department of Health and Human Services reported that as of April 19, 2014, 89% of those enrolled in the Indiana exchange were eligible for federal assistance. Our assumption is that this percentage will decrease during 2015.

7) Credibility of Experience

IUHP has not previously operated in the individual market. As a result the “Experience Period” section of Worksheet 1 of the URRT has not been populated. Similarly, the projection factors (cells J24:M29 on Worksheet 1) have also been left blank. The service category PMPMs shown in the “Credibility Manual” section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

8) Paid to Allowed Ratio

The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT calculates the PMPM costs on both an allowed and paid basis. The “Paid to Allowed Average Factor in Projection Period” shown on Worksheet 1, Section III of the URRT is developed by membership-weighted EHB paid claims divided by membership-weighted EHB allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

9) Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, IUHP is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value. Therefore, no risk adjustment PMPM payment is assumed for 2015.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only)

The Federal transitional reinsurance program is a temporary risk mitigation program expected to reduce costs for insurance issuers. The 2015 reinsurance program has an attachment point of $70,000 and a maximum coverage limit of $250,000 per member. The Department of Health and Human Services will reimburse insurance issuers 50% of paid costs between the attachment point and maximum coverage limit.

Allowed claims were reduced by 7.0% to account for the anticipated 2015 reimbursements from this temporary program. This estimate was developed using projected paid claims, a claims probability distribution calibrated to the expected average claim levels for the 2015 Individual market, and the federal program guidelines summarized above. The expected reinsurance reimbursements are $46.95 PMPM. Applying the 2015 transitional reinsurance charge of $3.67 PMPM yields a net reinsurance cost of $43.28 PMPM.

Projected Net Cost of Private Reinsurance

The projected net cost of private reinsurance for 2015 is $0.00 PMPM since IUHP does not intend to purchase private reinsurance.

10) Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

IUHP developed their expected administrative expenses based on: a) current administrative expenses for their Medicare line of business adjusting for any expected differences for their Commercial products, and b) a review of 2014 Rate Filings for Individual Exchange products. A summary of IUHP's assumptions is as follows:

- Administrative expenses (excluding Sales and Marketing expenses): 10.50% of premium
- Sales and Marketing expenses (including commissions): $6.18 PMPM

These administrative expenses are allocated proportionally by plan.

Quality Improvement Expenses

At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. Therefore, no explicit Quality Improvement expenses were assumed.

Profit & Risk Margin

The proposed rates reflect a profit & risk margin of 3.0% of premium. This load was applied to all products and plans.

Taxes and Fees

A summary of the assumed taxes and fees are summarized below:

PMPM Basis

- Transitional reinsurance charge: $3.67 PMPM ($44.00 per member per year)
- Risk adjustment user fee: $0.08 PMPM
- PCORI fee: $0.17 PMPM ($2.00 per member per year)

Percentage of Premium Basis

- Health insurance exchange fee: 3.15% of premium reflecting IUHP's assumption that 90% of their expected 2015 business will be sold through the exchange
- ACA issuer fee: IUHP will not be subject to this fee for 2015
- Premium tax: 1.30% of premium

11) Projected Loss Ratio

The overall projected medical loss ratio for 2015 is 85.2%. This calculation excludes regulatory fees and taxes. At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. As a result, we have not included an adjustment in the MLR calculation for these expenses. It is IUHP's intent to identify their Quality Improvement expenses for purposes of submitting their MLR-related filings and calculating related rebates, if any. The following table shows the calculation.

a)	Incurred Claims Net of Cost Sharing	$455.14
b)	Transitional Reinsurance Reimbursement	($46.95)
c)	Reinsurance Charge	$3.67
d)	Quality Improvement Expenses	$0.00
e)	Worksheet 1 Projected Incurred Claims (a+b+c+d)	$411.86
f)	Administrative Expenses	$59.70
g)	Profit & Risk Margin	$15.29
h)	Regulatory Taxes and Fees (excluding reinsurance charge)	$22.93
i)	Gross Premium (e+f+g+h)	$509.79
j)	Medical Loss Ratio (e/(i-c-h))	85.2%

12) Single Risk Pool

IUHP has not previously operated in the Individual market and thus does not have any claims experience to develop its own Single Risk Pool. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

13) Index Rate

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the Index Rate for the Experience Period has been left blank.

The Index Rate of $670.70 for the 2015 Projection Period represents the overall projected allowed costs PMPM for providing Essential Health Benefits for the Single Risk Pool. Since this is a new product, the index rate was developed based on a manual rate as described above in the Credibility Manual Rate Development section. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

14) Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic

characteristics of the Single Risk Pool. In other words, the Market Adjusted Index Rate is not calibrated.

The development of the Federal reinsurance program and risk adjustments was described above in the Risk Adjustment and Reinsurance section. The development of the Exchange user fee adjustment was described above in the Non-Benefit Expenses and Profit & Risk section.

Index Rate	$670.70
Reinsurance Reimbursements (7.0% of Allowed Claims – Index Rate)	($46.95)
Reinsurance Premiums	$ 3.67
Risk Adjustment	$ 0.00
Exchange user fee (3.15% of average premium for Single Risk Pool)	$ 16.06
Market Adjusted Index Rate	$643.47

15) Plan Adjusted Index Rates

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the Part I Unified Rate Review Template in 2015. These Plan Adjusted Index Rates have been adjusted to remove the portion of the allowed cost that is expected to be recouped through the tobacco surcharge. The average tobacco surcharge for the Single Risk Pool is approximately 1.4%.

The Plan Adjusted Index Rates reflect the average demographic characteristics of the Single Risk Pool. In other words, the Plan Adjusted Index Rates are not calibrated.

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

- Actuarial value and cost sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)
- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

Only the actuarial value and cost sharing & distribution and administrative costs adjustments were applicable to IUHP.

Actuarial Value and Cost Sharing Adjustment

This adjustment includes three components:

- Removal of tobacco surcharge - the average tobacco surcharge factor was applied to the average allowed costs for the Single Risk Pool
- Benefit richness utilization adjustments - The reference plan underlying our pricing was a Silver plan. Benefit richness utilization adjustments were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge). These

adjustments were based on the values published in the Federal Register payment notice, normalized to the Silver plan level. The adjustments for each metallic tier are as follows:

- Bronze = 1.00 / 1.03 = 0.9709
- Silver = 1.00 / 1.00 = 1.0000
- Gold = 1.08 / 1.03 = 1.0485

- Cost Sharing - The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT was used to calculate the cost sharing percentage for each plan. These cost sharing percentages were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge and applying the benefit richness utilization adjustments). The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

Adjustment for Distribution and Administrative Costs

Fixed and variable costs as described in the Non-Benefit Expenses and Profit & Risk section were included in this adjustment as follows:

- Fixed costs: Risk adjustment user fee, PCORI fee, and sales & marketing expenses
- Variable costs (% of premium): Administrative expenses, profit & risk margin, and premium taxes. The percentages applied did not vary by plan.

Appendix D shows the development of the Plan Adjusted Index Rates.

16) Calibration

The Plan Adjusted Index Rates (which are based on the Single Risk Pool) were calibrated to apply the allowable rating factors in order to calculate Consumer Adjusted Premium Rates. The calibration by age and geography is described below.

Age Curve Calibration

The methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology and conforms with the rating rules specified in 45 CFR 147.102.

The expected membership distribution by age band was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. A uniform distribution within each age band was also assumed. A weighted average age factor of 1.685 for the Single Risk Pool was also determined by applying the membership distribution to the Federal age curve. This represents a rounded weighted average age of 49. Appendix C shows the development of the weighted average age factor.

The Plan Index Rates were calibrated by dividing by 1.706 which represents the standard age factor of the rounded weighted average age of 49. This calibration factor does not vary by plan.

Geographic Factor Calibration

A geographic factor calibration was not required since the weighted average of the geographic factors equals 1.0. The Geographic (rating area) factors were developed based upon the network characteristics for unit cost and utilization management in each of the established rating areas. Based upon the expected distribution of enrolment by area, the area factors reflect the Single Risk Pool results consistent with the URRT.

Appendix D shows how the calibration adjustments were applied to the Plan Adjusted Index Rates.

17) Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography if necessary, and applying the rating factors specified by 45 CFR Part 147, §147.102. The following adjustments are allowable under this rule:

- Whether the plan coverage covers an individual or family (issuers must cover any eligible individual and/or eligible family that requests coverage per the guaranteed issue requirement of the ACA); this is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor
- Rating area
- Age – reflecting the applicable age curve
- Tobacco status

The rating factors (shown in Appendix C) are applied at an individual level and added together to calculate the family rate, with the exception that no more than 3 covered children under the age of 21 are charged a rate. Adjustment for family size is in accordance with Federal rules. The examples in Appendix E show how the rating factors are applied to the calibrated Plan Adjusted Index Rate.

18) AV Metal Values

The Federal AV calculator was used without any modifications to generate the Metal Values included in Worksheet 2 of the URRT. Please refer to Appendix F for screen shots showing the AV calculations for each plan.

19) AV Pricing Values

The Silver Value plan was selected as the fixed reference plan and serves as the basis for the AV Pricing Values. Please refer to Appendix C for the AV Pricing Values for each plan which are also included in Worksheet 2, Section I of the URRT. The AV Pricing Value for each plan reflects the relative impact of the plan's cost-sharing amounts, expected impact on enrollee utilization due to benefit richness (excluding impact of morbidity), expected additional cost of non-EHB, and administrative expenses (excluding health insurance exchange user fees).

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the PwC Rating Model as described above in the Credibility Manual Rate Development section was used to develop the benefit relativities for the AV Pricing Values.

20) Membership Projections

Membership projections were based on market penetration assumptions provided by IUHP. These assumptions reflected the uninsured and individual market populations by county, income level, and other characteristics such as the presence of IUHP facilities and delivery system within a given county.

The expected membership distribution by age band and metallic tier was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. For the Silver plans, the portion of the projected enrollment that will be eligible for CSR subsidies at each subsidy level was based on the income level detail in the market penetration analysis provided by IUHP.

Summaries of the projected membership by age, metallic tier, and CSR subsidy level are shown in Appendix B.

21) Terminated Products

Not applicable. IUHP does not currently have Individual plans in the State of Indiana.

22) Plan Type

All plans listed types in Worksheet 2, Section I of the URRT correctly describe IUHP's plans as "HMO".

23) Warning Alerts

There were no warnings generated on Worksheet 2 of in the URRT.

24) Company Financial Position

Please see Appendix G for information regarding the capital and surplus position of IUHP.

25) Reliance

In the preparation of this filing, I have relied upon data provided by Eric Neuville (Vice President Product Development and Innovation), Connie Brown (CFO and COO), and IUHP management. I did not audit this data but did review it for reasonableness. This information includes but is not limited to the following items:

- Administrative expense projections (including commissions)
- Provider reimbursement levels (including capitation arrangements)
- Projected enrollment
- Projected pharmacy discounts, unit costs and rebates
- Financial statement information

26) Actuarial Certification

I, Robert Macagnano, FSA, MAAA, am affiliated with PricewaterhouseCoopers LLP (PwC). I am a Member of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinion contained herein. This filing is prepared on behalf of Indiana University Health Plans, Inc. (the "Company").

I certify that this filing has been prepared in accordance with the following Actuarial Standards of Practice (ASOP) including:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications

I certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

I certify that the Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

On/Off Exchange Attestation

I certify that a single set of premium rates was submitted with this filing which is applicable for all plans offered both on and off the Exchange, and that this assures the same premium rate will be charged without regard to whether the plan is offered through the Exchange or whether the plan is offered directly from the Company or through an agent.

QHP Off Exchange Premium Tax Credit (PTC) Attestation

To notify consumers that coverage purchased outside of the Exchange is not eligible for premium tax credit assistance, the Company will include the following language in their marketing materials:

"DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace."

This disclaimer is located on page 1 of the Company's policy form.

The Part I Unified Rate Review Template does not demonstrate the process used by the Company to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Respectfully submitted,



Robert Macagnano, FSA, MAAA
Director
(973) 236-4082
Robert.Macagnano@us.pwc.com

Appendix A
Indiana University Health Plans, Inc.
Plan Design Summaries

Plan Name	Deductible	OOP Max	Coinsurance	PCP Visit	Specialist Visit	ER Visit	Inpatient Stay	Rx - Retail	Rx - Mail Order
IU Health Plans Gold Value	$750/$1,500	$6,000/$12,000	20% after deductible	$20 copay	$50 copay before deductible and 20% after deductible	$200 copay then deductible and 20% coinsurance	$500 copay then deductible and 20% coinsurance	$8/$20/20%/30%/30% (coinsurance applies after deductible)	$24/$60/20%/30%/30% (coinsurance applies after deductible)
IU Health Plans Silver HSA	$2,750/$5,500	$3,600/$7,200	10% after deductible	10% after deductible	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% after deductible	$15/$45/25%/35%/35% after deductible
IU Health Plans Silver Value	$2,500/$5,000	$6,350/$12,700	10% after deductible	$40 copay	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Silver Enhanced	$2,000/$4,000	$5,750/$11,500	20% after deductible	$30 copay	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Bronze HSA	$4,500/$9,000	$6,350/$12,700	20% after deductible	20% after deductible	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$10/$25/30%/40%/40% after deductible	$30/$75/30%/40%/40% after deductible
IU Health Plans Bronze Value	$6,000/$12,000	$6,350/$12,700	25% after deductible	$40 copay	25% after deductible	$350 copay then deductible and 25% coinsurance	$1,500 copay then deductible and 25% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)
IU Health Plans Bronze Enhanced	$5,000/$10,000	$6,350/$12,700	40% after deductible	$50 copay before deductible and then 40% after deductible	40% after deductible	$275 copay then deductible and 40% coinsurance	$750 copay then deductible and 40% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area

Member Distribution by Age	
Age Band	**Membership Distribution**
0-20	10.15%
21	1.09%
22	1.09%
23	1.09%
24	1.09%
25	1.09%
26	1.85%
27	1.85%
28	1.85%
29	1.85%
30	1.85%
31	1.85%
32	1.85%
33	1.85%
34	1.85%
35	1.68%
36	1.68%
37	1.68%
38	1.68%
39	1.68%
40	1.68%
41	1.68%
42	1.68%
43	1.68%
44	1.68%
45	2.12%
46	2.12%
47	2.12%
48	2.12%
49	2.12%
50	2.12%
51	2.12%
52	2.12%
53	2.12%
54	2.12%
55	2.98%
56	2.98%
57	2.98%
58	2.98%
59	2.98%
60	2.98%
61	2.98%
62	2.98%
63	2.98%
64	2.98%
65 and over	0.00%

Membership Distribution by Rating Area	
Rating Area	**Membership Distribution**
5	4.5%
7	30.9%
8	17.7%
10	9.0%
11	2.9%
13	29.9%
15	5.1%
Total	**100.0%**

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area
(continued)

		Silver					
Plan Name	**Gold**	**70**	**CSR 73**	**CSR 87**	**CSR 94**	**Bronze**	**Total**
IU Health Plans Gold Value	73						73
IU Health Plans Silver HSA		28	-	-	-		28
IU Health Plans Silver Value		168	152	284	69		673
IU Health Plans Silver Enhanced		84	76	142	35		337
IU Health Plans Bronze HSA						35	35
IU Health Plans Bronze Value						210	210
IU Health Plans Bronze Enhanced						105	105
Total	73	280	229	426	104	351	1,462

Appendix C
Indiana University Health Plans, Inc.
Rating Factors

Age-Based Tobacco Factors		
Age	**Smoker**	**Non-smoker**
0-20	1.000	1.000
21	1.050	1.000
22	1.050	1.000
23	1.050	1.000
24	1.050	1.000
25	1.050	1.000
26	1.050	1.000
27	1.050	1.000
28	1.050	1.000
29	1.050	1.000
30	1.050	1.000
31	1.070	1.000
32	1.090	1.000
33	1.110	1.000
34	1.130	1.000
35	1.150	1.000
36	1.170	1.000
37	1.190	1.000
38	1.210	1.000
39	1.230	1.000
40	1.250	1.000
41	1.270	1.000
42	1.290	1.000
43	1.310	1.000
44	1.330	1.000
45	1.350	1.000
46	1.370	1.000
47	1.390	1.000
48	1.410	1.000
49	1.430	1.000
50	1.450	1.000
51	1.470	1.000
52	1.490	1.000
53	1.490	1.000
54	1.473	1.000
55	1.410	1.000
56	1.348	1.000
57	1.290	1.000
58	1.234	1.000
59	1.208	1.000
60	1.158	1.000
61	1.118	1.000
62	1.094	1.000
63	1.065	1.000
64	1.048	1.000
65 and over	1.048	1.000

Federal Age Curve		
Age Band	**Membership Distribution**	**Age Factor**
0-20	10.15%	0.635
21	1.09%	1.000
22	1.09%	1.000
23	1.09%	1.000
24	1.09%	1.000
25	1.09%	1.004
26	1.85%	1.024
27	1.85%	1.048
28	1.85%	1.087
29	1.85%	1.119
30	1.85%	1.135
31	1.85%	1.159
32	1.85%	1.183
33	1.85%	1.198
34	1.85%	1.214
35	1.68%	1.222
36	1.68%	1.230
37	1.68%	1.238
38	1.68%	1.246
39	1.68%	1.262
40	1.68%	1.278
41	1.68%	1.302
42	1.68%	1.325
43	1.68%	1.357
44	1.68%	1.397
45	2.12%	1.444
46	2.12%	1.500
47	2.12%	1.563
48	2.12%	1.635
49	2.12%	1.706
50	2.12%	1.786
51	2.12%	1.865
52	2.12%	1.952
53	2.12%	2.040
54	2.12%	2.135
55	2.98%	2.230
56	2.98%	2.333
57	2.98%	2.437
58	2.98%	2.548
59	2.98%	2.603
60	2.98%	2.714
61	2.98%	2.810
62	2.98%	2.873
63	2.98%	2.952
64	2.98%	3.000
65 and over	0.00%	3.000
Weighted average age factor		1.685

Appendix C
Indiana University Health Plans, Inc.
Rating Factors
(continued)

Geographic Factors		
Rating Area	**Membership Distribution**	**Rating Area Factor**
5	4.5%	0.976
7	30.9%	0.976
8	17.7%	1.006
10	9.0%	1.060
11	2.9%	0.972
13	29.9%	1.010
15	5.1%	0.998
Total	**100.0%**	**1.000**

Plan Value Factors	
Plan Name	**Pricing Value**
IU Health Plans Gold Value	1.203
IU Health Plans Silver HSA	0.990
IU Health Plans Silver Value	1.000
IU Health Plans Silver Enhanced	1.009
IU Health Plans Bronze HSA	0.802
IU Health Plans Bronze Value	0.824
IU Health Plans Bronze Enhanced	0.834

Appendix D
Indiana University Health Plans, Inc.
Plan Adjusted Index Rate Development

Plan Name	Market adjusted index rate (a)	Actuarial value and cost sharing adjustment (b)	Adjustment for distribution and administrative costs (c)	Plan adjusted index rate (d) = (a) + (b) + (c)	Age calibration (e)	Geographic calibration (f)	Calibrated base rate (g) = (d) / [(e) x (f)]
IU Health Plans Gold Value	$ 643.47	$(120.70)	$98.43	$621.20	1.706	1.000	$364.13
IU Health Plans Silver HSA	$ 643.47	$(214.09)	$82.06	$511.44	1.706	1.000	$299.79
IU Health Plans Silver Value	$ 643.47	$(209.80)	$82.80	$516.48	1.706	1.000	$302.74
IU Health Plans Silver Enhanced	$ 643.47	$(205.97)	$83.47	$520.97	1.706	1.000	$305.38
IU Health Plans Bronze HSA	$ 643.47	$(296.83)	$67.60	$414.24	1.706	1.000	$242.81
IU Health Plans Bronze Value	$ 643.47	$(287.20)	$69.27	$425.54	1.706	1.000	$249.44
IU Health Plans Bronze Enhanced	$ 643.47	$(282.71)	$70.05	$430.81	1.706	1.000	$252.53

Appendix E
Indiana University Health Plans, Inc.
Rating Examples

Selected Plan:	IU Health Plans Silver Value
Rating Area:	Rating Area 11

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$302.74	0.972	2.230	1.410	$925.37
Spouse	40	Non-Smoker	$302.74	0.972	1.278	1.000	$376.12
Child 1	18	Non-Smoker	$302.74	0.972	0.635	1.000	$186.88
Child 2	15	Smoker	$302.74	0.972	0.635	1.000	$186.88
Child 3	13	Non-Smoker	$302.74	0.972	0.635	1.000	$186.88
Child 4	10	Non-Smoker	$302.74	0.972	0.635	1.000	$0.00
Total Premium							$1,862.13

Selected Plan:	IU Health Plans Gold Value
Rating Area:	Rating Area 7

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$364.13	0.976	2.230	1.410	$1,117.24
Spouse	40	Non-Smoker	$364.13	0.976	1.278	1.000	$454.10
Child 1	18	Non-Smoker	$364.13	0.976	0.635	1.000	$225.63
Child 2	15	Smoker	$364.13	0.976	0.635	1.000	$225.63
Child 3	13	Non-Smoker	$364.13	0.976	0.635	1.000	$225.63
Child 4	10	Non-Smoker	$364.13	0.976	0.635	1.000	$0.00
Total Premium							$2,248.24

Appendix F
Indiana University Health Plans, Inc.
Federal AV Calculator Results

IU Health Plans Gold Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☑		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.80	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.4%
Metal Tier:	Gold

IU Health Plans Silver HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.0%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.1%
Metal Tier:	Gold

IU Health Plans Silver HSA - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$400.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.1%
Metal Tier:	Platinum

IU Health Plans Silver Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.4%
Metal Tier:	Gold

IU Health Plans Silver Value - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

IU Health Plans Silver Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑All	☑All			☑All	☑All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐All	☐All			☑All	☑All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.7%
Metal Tier:	Gold

IU Health Plans Silver Enhanced - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$150.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$650.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

IU Health Plans Bronze HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.6%
Metal Tier:	Bronze

IU Health Plans Bronze Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	**Drug**	**Combined**	**Medical**	**Drug**	**Combined**
		$6,000.00			
		75.00%			
		$6,350.00			

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$350.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze

IU Health Plans Bronze Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,350.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$275.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☑		$50.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.8%
Metal Tier:	Bronze

Appendix G
Indiana University Health Plans, Inc.
Capital, Surplus, and RBC Information

Annual Statement for the year 2013 of the Indiana University Health Plans, Inc.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)				
2. Stocks (Schedule D):				
2.1 Preferred stocks				
2.2 Common stocks				
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens				
3.2 Other than first liens				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ encumbrances)				
4.2 Properties held for the production of income (less $ encumbrances)				
4.3 Properties held for sale (less $ encumbrances)				
5. Cash ($ 6,645,144, Schedule E - Part 1), cash equivalents ($, Schedule E - Part 2), and short-term investments ($, Schedule DA)	6,645,144		6,645,144	8,006,798
6. Contract loans (including $ premium notes)				
7. Derivatives (Schedule DB)				
8. Other invested assets (Schedule BA)				
9. Receivables for securities				
10. Securities lending reinvested collateral assets (Schedule DL)				
11. Aggregate write-ins for invested assets				
12. Subtotals, cash and invested assets (Lines 1 to 11)	6,645,144		6,645,144	8,006,798
13. Title plants less $ charged off (for Title insurers only)				
14. Investment income due and accrued	1,068		1,068	2,137
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	231,209	66,791	164,418	201,607
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ earned but unbilled premiums)				
15.3 Accrued retrospective premiums				
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers				
16.2 Funds held by or deposited with reinsured companies				
16.3 Other amounts receivable under reinsurance contracts				
17. Amounts receivable relating to uninsured plans				
18.1 Current federal and foreign income tax recoverable and interest thereon				
18.2 Net deferred tax asset				
19. Guaranty funds receivable or on deposit				
20. Electronic data processing equipment and software				
21. Furniture and equipment, including health care delivery assets ($)				
22. Net adjustment in assets and liabilities due to foreign exchange rates				
23. Receivables from parent, subsidiaries and affiliates	332,038		332,038	714,499
24. Health care ($ 449,493) and other amounts receivable	1,838,476	915,716	922,760	616,348
25. Aggregate write-ins for other than invested assets	1,110,648	156,922	953,726	510,111
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	10,158,583	1,139,429	9,019,154	10,051,500
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28. Total (Lines 26 and 27)	10,158,583	1,139,429	9,019,154	10,051,500

DETAILS OF WRITE-IN LINES				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	NONE			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501. Estimated Medicare Settlement Receivable	953,726		953,726	510,111
2502. Prepaid General and Administrative Expenses	156,922	156,922		
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page				
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	1,110,648	156,922	953,726	510,111

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ 0 reinsurance ceded)				
2.	Accrued medical incentive pool and bonus amounts				
3.	Unpaid claims adjustment expenses				
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Services Act	29,399		29,399	105,075
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	294,066		294,066	229,823
9.	General expenses due or accrued	818,192		818,192	1,431,649
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))				
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others				
13.	Remittances and items not allocated				
14.	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)				
15.	Amounts due to parent, subsidiaries and affiliates				12,550
16.	Derivatives				
17.	Payable for securities				
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified $ (0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans				
23.	Aggregate write-ins for other liabilities (including $ 0 current)	595,407		595,407	871,800
24.	Total liabilities (Lines 1 to 23)	1,737,064		1,737,064	2,650,897
25.	Aggregate write-ins for special surplus funds	XXX	XXX		
26.	Common capital stock	XXX	XXX	1,000	1,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	27,499,000	27,999,000
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	(20,217,910)	(20,599,397)
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX		
	32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	7,282,090	7,400,603
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	9,019,154	10,051,500

	DETAILS OF WRITE-IN LINES				
2301.	Estimated Medicare Settlement Liability	338,139		338,139	667,855
2302.	Other Amounts Payable	257,268		257,268	203,945
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	595,407		595,407	871,800
2501.		XXX	XXX		
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

NONE

NONE

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL - XR025

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		7,282,090	
(2)	Company Action Level=200% of Authorized Control Level	CAL	4,146,860	
(3)	Regulatory Action Level=150% of Authorized Control Level	RAL	3,110,145	
(4)	Authorized Control Level=100% of Authorized Control Level	ACL	2,073,430	
(5)	Mandatory Control Level=70% of Authorized Control Level	MCL	1,451,401	
(6)	Level of Action, if Any		NONE	

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	7,282,090
Authorized Control Level Risk-Based Capital on Line 15 of the Five Year Historical Data Page	2,073,430

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	98,250,957	
(8)	Underwriting Deductions	Page 4, Line 23	97,709,883	
(9)	Combined Ratio	Line (8)/Line(7)	99.400	
(10)	RBC Ratio	Line(1)/Line(4)	351.200	
(11)	Trend Test Result	If Line(10) is between 200% and 300% and Line (9) > 105%, then "Yes", otherwise "No"		No
(12)	Level of Action, if any, including Trend Test		NONE	

FLESCH TEST
CERTIFICATE OF COMPLIANCE

To: Indiana Department of Insurance
RE: SERFF Filing No. IUHP-129535085

I hereby certify that, to the best of my knowledge, the filings listed below meet the minimum reading ease score of the Flesch Readability Test required by Ind. Code § 27-1-26-1 *et seq*.

Pursuant to Ind. Code § 27-1-26-1(e), the following language or terminology has been excepted from scoring and is entitled to be excepted as indicated:

- The name and address of Indiana University Health Plans, Inc.;
- The name, number and title of 13164.1 – Indiv – Policy – Adult (01/2015);
- The titles, captions and sub captions within 13164.1 – Indiv – Policy – Adult (01/2015);
- Table of contents of 13164.1 – Indiv – Policy – Adult (01/2015);
- Schedules or tables;
- Language within 13164.1 – Indiv – Policy – Adult (01/2015) drafted to conform to the requirements of federal law, regulation, or federal agency interpretation;
- Medical terminology; and
- Words defined in 13164.1 – Indiv – Policy – Adult (01/2015).

Constance D. Brown
COO/CFO
Indiana University Health Plans, Inc.

5/8/2014
Date

FLESCH TEST
CERTIFICATE OF COMPLIANCE

To: Indiana Department of Insurance
RE: SERFF Filing No. IUHP-129535085

I hereby certify that, to the best of my knowledge, the filings listed below meet the minimum reading ease score of the Flesch Readability Test required by Ind. Code § 27-1-26-1 *et seq.*

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- The name and address of Indiana University Health Plans, Inc.;
- The name, number and title of 13164.1 – Indiv – Policy – Child (01/2015);
- The titles, captions and sub captions within 13164.1 – Indiv – Policy – Child (01/2015);
- Table of contents of 13164.1 – Indiv – Policy – Child (01/2015);
- Schedules or tables;
- Language within 13164.1 – Indiv – Policy – Child (01/2015) drafted to conform to the requirements of federal law, regulation, or federal agency interpretation;
- Medical terminology; and
- Words defined in 13164.1 – Indiv – Policy – Child (01/2015).

Constance D. Brown

Constance D. Brown
COO/CFO
Indiana University Health Plans, Inc.

5/8/2014
Date

STATEMENT OF VARIABILITY

Indiana University Health Plans, Inc.
Individual HMO/HSA – On and Off Exchange Product
Contract Form #13164.1-Indiv-Policy-Adult (01/2015)

General Variable Information

Some numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

Paragraph numbering will vary for products purchased on the Indiana Marketplace and products purchased off the Indiana Marketplace.

Definitions may vary to the extent that such definition may be included, omitted, or transferred to another page as appropriate for products purchased on the Indiana Marketplace and products purchased off the Indiana Marketplace.

Website URL addresses, telephone numbers, and addresses are bracketed throughout the Contract for removal if necessary or to update if the references change.

We also reserve the right to amend the form to fix any minor typographical errors we may have neglected to find prior to submitting for approval.

Please note that the deductible, out of pocket maximum and cost share value ranges brackets in the schedule will only be arranged to match our company's individual benefit/metal plan offerings. At no time will this variable information be arranged in such a way as to violate the laws of the State of Indiana.

The following is an explanation of the variables used within this Contract form:

FRONT COVER:

Indiana Marketplace referenced on the front cover page may or may not appear depending on whether a consumer's product selection is on or off the Indiana Marketplace.

Product Name is bracketed to allow for different names to appear depending on a consumer's benefit selection. The metal level names are:

IU Health Plans Bronze HSA

IU Health Plans Bronze Value

IU Health Plans Bronze Enhanced

IU Health Plans Silver HSA

IU Health Plans Silver Value

IU Health Plans Silver Enhanced

IU Health Plans Silver HSA 73

IU Health Plans Silver Value 73

IU Health Plans Silver Enhanced 73

IU Health Plans Silver HSA 87

IU Health Plans Silver Value 87

IU Health Plans Silver Enhanced 87

IU Health Plans Silver HSA 94

IU Health Plans Silver Value 94

IU Health Plans Silver Enhanced 94

IU Health Plans Gold Value

Logo, Company Name and Company Address are bracketed throughout the entire policy form to allow for future change.

Disclaimer will only appear if the consumer selects a plan offered off the Indiana Marketplace.

ARTICLE 1. DEFINITIONS

Introductory Sentence – Two versions of language are provided in brackets for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

Open Enrollment Period – Two versions of language are provided in brackets for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

Qualified Individual – This definition will appear in all Indiana Marketplace products selected.

Special Enrollment Periods – Two versions of language are provided in brackets for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT

Introductory Sentence – This statement will appear in all Indiana Marketplace products selected.

A. You as an Individual – Two versions of language are provided in brackets in (1), (2) and (3) for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

C. Other Rules About Eligibility – This statement will appear in all non-Indiana Marketplace products selected.

D. Open Enrollment – Two versions of language are provided in brackets in D(1) for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products. The language provided in D. (2), (3) and (4) is in brackets for flexibility if these timeframes change.

E. Special Enrollment/Changes Affecting Eligibility and Special Enrollment Periods – Two versions of language are provided in brackets for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

F. Adding New Dependents Under A Special Enrollment – Two versions of language are provided in brackets throughout this section for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

G. Notification of Changes – Two versions of language are provided in brackets in G (1), (2) and (3) for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

G.(4) Statements and Forms – This statement will appear in all non-Indiana Marketplace products selected.

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A.(1)(a) Premium – Two versions of language are provided in brackets for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

B. Grace Period – The statements in (1) and (2) will appear in all Indiana Marketplace products, and the statement in (1) will appear in all non-Indiana Marketplace products.

ARTICLE 10. TERMINATION OF COVERAGE

A. Guaranteed Renewable – Two versions of language are provided in brackets for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

B. Termination – The language provided in brackets throughout this section will appear in the Indiana Marketplace products.

C. Effective Date of Termination – Two versions of language are provided in brackets throughout this section for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

G. Reinstatement – Two versions of language are provided in brackets throughout this section for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

H. Certification of Prior Creditable Coverage If Required by Law – Bracketed to allow for flexibility if this requirement changes.

SCHEDULE OF BENEFITS

Subscriber, Subscriber ID, Dependent, Effective Date, and Plan Year – Bracketed to provide an enrollee's specific details upon enrollment in a particular product.

STATEMENT OF VARIABILITY

Indiana University Health Plans, Inc.
Individual HMO/HSA – On and Off Exchange Product
Contract Form #13164.1-Indiv-Policy-Child (01/2015)

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Some numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

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Please note that the deductible, out of pocket maximum and cost share value ranges brackets in the schedule will only be arranged to match our company's individual benefit/metal plan offerings. At no time will this variable information be arranged in such a way as to violate the laws of the State of Indiana.

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IU Health Plans Silver HSA 73

IU Health Plans Silver Value 73

IU Health Plans Silver Enhanced 73

IU Health Plans Silver HSA 87

IU Health Plans Silver Value 87

IU Health Plans Silver Enhanced 87

IU Health Plans Silver HSA 94

IU Health Plans Silver Value 94

IU Health Plans Silver Enhanced 94

IU Health Plans Gold Value

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ARTICLE 2. ELIGIBILITY AND ENROLLMENT

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A. The Covered Person as an Individual – Two versions of language are provided in brackets in (1), (2) and (3) for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

B. Other Rules About Eligibility – This statement will appear in all non-Indiana Marketplace products selected.

C. Open Enrollment – Two versions of language are provided in brackets in D(1) for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products. The language provided in D. (2), (3) and (4) is in brackets for flexibility if these timeframes change.

D. Special Enrollment/Changes Affecting Eligibility and Special Enrollment Periods – Two versions of language are provided in brackets for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

E. Adding New Dependents Under A Special Enrollment – Two versions of language are provided in brackets throughout this section for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

F. Notification of Changes – Two versions of language are provided in brackets in G (1), (2) and (3) for flexibility. One version for the Indiana Marketplace products and one version for the non-Indiana Marketplace products.

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SCHEDULE OF BENEFITS

Subscriber, Subscriber ID, Dependent, Effective Date, and Plan Year – Bracketed to provide an enrollee's specific details upon enrollment in a particular product.

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page	35	of	Contract
Specialist Visit	See Page	35	of	Contract
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page	35	of	Contract
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page	34	of	Contract
Outpatient Surgery Physician/Surgical Services	See Page	34	of	Contract
Hospice Services	See Page	26	of	Contract
Private-Duty Nursing	See Page	25	of	Contract
Urgent Care Centers or Facilities	See Page	24	of	Contract
Home Health Care Services	See Page	25	of	Contract
Emergency Room Services	See Page	24	of	Contract
Emergency Transportation/Ambulance	See Page	19	of	Contract
Inpatient Hospital Services (e.g., Hospital Stay)	See Page	26-27	of	Contract
Inpatient Physician and Surgical Services	See Page	26-27	of	Contract
Skilled Nursing Facility	See Page	26	of	Contract
Prenatal and Postnatal Care	See Page	27-28	of	Contract
Delivery and All Inpatient Services for Maternity Care	See Page	27-28	of	Contract
Mental/Behavioral Health Outpatient Services	See Page	20	of	Contract
Mental/Behavioral Health Inpatient Services	See Page	20	of	Contract
Substance Abuse Disorder Outpatient Services	See Page	20	of	Contract
Substance Abuse Disorder Inpatient Services	See Page	20	of	Contract
Generic Drugs	See Page	49	of	Contract
Preferred Brand Drugs	See Page	49	of	Contract
Non-Preferred Brand Drugs	See Page	49	of	Contract
Specialty Drugs	See Page	49	of	Contract
Outpatient Rehabilitation Services	See Page	40-43	of	Contract
Habilitation Services	See Page	40-43	of	Contract
Chiropractic Care	See Page	41	of	Contract
Durable Medical Equipment	See Page	30	of	Contract
Imaging (CT/PET Scans, MRIs)	See Page	23	of	Contract
Preventive Care/Screening/Immunization	See Page	36-38	of	Contract

Routine Eye Exam for Children	See Page	51	of	Contract
Eye Glasses for Children	See Page	51	of	Contract
Dental Check-Up for Children	See Page	N/A	of	Contract
Rehabilitative Speech Therapy	See Page	41	of	Contract
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page	40-41	of	Contract
Well Baby Visits and Care	See Page	36	of	Contract
Laboratory Outpatient and Professional Services	See Page	23	of	Contract
X-rays and Diagnostic Imaging	See Page	23	of	Contract
Basic Dental Care – Child	See Page	N/A	of	Contract
Orthodontia – Child	See Page	N/A	of	Contract
Major Dental Care – Child	See Page	N/A	of	Contract
Transplant	See Page	43-45	of	Contract
Accidental Dental	See Page	22	of	Contract
Dialysis	See Page	34	of	Contract
Allergy Testing	See Page	23	of	Contract
Chemotherapy	See Page	42	of	Contract
Radiation	See Page	42	of	Contract
Diabetes Education	See Page	23	of	Contract
Prosthetic Devices	See Page	31	of	Contract
Infusion Therapy	See Page	26	of	Contract
Treatment for Temporomandibular Joint Disorders	See Page	39-41	of	Contract
Nutritional Counseling	See Page	25	of	Contract
Reconstructive Surgery	See Page	38-39	of	Contract
Clinical Trials	See Page	21	of	Contract
Diabetes Care Management	See Page	22-23	of	Contract
Inherited Metabolic Disorder - PKU	See Page	30	of	Contract
Off Label Prescription Drugs	See Page	61	of	Contract
Dental Anesthesia	See Page	22	of	Contract
Mental Health Other	See Page	20	of	Contract

I, on behalf of Indiana University Health Plans hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by Indiana University Health Plans for review and approval.

Constance D Brown — COO/CFO — 5/8/2014

Name:Constance D. Brown Title: COO/CFO Date: May 8, 2014

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page	35	of	Contract
Specialist Visit	See Page	35	of	Contract
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page	35	of	Contract
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page	34	of	Contract
Outpatient Surgery Physician/Surgical Services	See Page	34	of	Contract
Hospice Services	See Page	26	of	Contract
Private-Duty Nursing	See Page	25	of	Contract
Urgent Care Centers or Facilities	See Page	24	of	Contract
Home Health Care Services	See Page	25	of	Contract
Emergency Room Services	See Page	24	of	Contract
Emergency Transportation/Ambulance	See Page	19	of	Contract
Inpatient Hospital Services (e.g., Hospital Stay)	See Page	26-27	of	Contract
Inpatient Physician and Surgical Services	See Page	26-27	of	Contract
Skilled Nursing Facility	See Page	26	of	Contract
Prenatal and Postnatal Care	See Page	27-28	of	Contract
Delivery and All Inpatient Services for Maternity Care	See Page	27-28	of	Contract
Mental/Behavioral Health Outpatient Services	See Page	20	of	Contract
Mental/Behavioral Health Inpatient Services	See Page	20	of	Contract
Substance Abuse Disorder Outpatient Services	See Page	20	of	Contract
Substance Abuse Disorder Inpatient Services	See Page	20	of	Contract
Generic Drugs	See Page	49	of	Contract
Preferred Brand Drugs	See Page	49	of	Contract
Non-Preferred Brand Drugs	See Page	49	of	Contract
Specialty Drugs	See Page	49	of	Contract
Outpatient Rehabilitation Services	See Page	40-43	of	Contract
Habilitation Services	See Page	40-43	of	Contract
Chiropractic Care	See Page	41	of	Contract
Durable Medical Equipment	See Page	30	of	Contract
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Constance D Brown

Name:Constance D. Brown

COO/CFO

Title: COO/CFO

5/8/2014

Date: May 8, 2014

[Insert logo left/center/right]

INDIVIDUAL CONTRACT
[Issued through the Indiana Marketplace]
(herein called the "Contract")

[Product Name]

Issued by:

Indiana University Health Plans, Inc.
an Indiana domestic health maintenance organization
950 North Meridian Street
Indianapolis, Indiana 46204

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[This coverage is issued through the Indiana Marketplace.] This Contract sets forth in detail your rights and obligations as a Subscriber. It is important that you **read this Contract carefully.** This Contract includes limitations and exclusions. You should familiarize yourself with its terms and conditions before receiving Health Care Services. Capitalized terms have the meaning set forth in the Definitions sections.

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, you may return it to us or the agent who sold it to you within 10 days after your receipt. Your premium will be refunded and this Contract with be void from its start. Any Health Care Services received during this 10-day period are solely your responsibility.

Benefits under this Contract may vary depending on other medical expense insurance you may have.

If you have questions related to your health insurance coverage, you may contact us at [toll free number] [or the Indiana Marketplace at www.healthcare.gov or [toll free number].]

[signature]
President

[**DISCLAIMER:** The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace.]

TABLE OF CONTENTS

PAGE

ARTICLE 1. DEFINITIONS 1
ARTICLE 2. ELIGIBILITY AND ENROLLMENT. 9
ARTICLE 3. YOUR FINANCIAL OBLIGATIONS 16
ARTICLE 4. COVERED SERVICES 19
ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS 54
ARTICLE 6. OBTAINING COVERED SERVICES 63
ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES 65
ARTICLE 8. PAYMENT FOR COVERED SERVICES 74
ARTICLE 9. COORDINATION OF BENEFITS 76
ARTICLE 10. TERMINATION OF COVERAGE 81
ARTICLE 11. GENERAL PROVISIONS 85

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Deleted: 77
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ARTICLE 1. DEFINITIONS

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, who obtained this coverage through the Indiana Marketplace.]

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[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.]

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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.

Approved Clinical Trial – a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

(a) A trial that is approved or funded by one, or a combination, of the following.

(a) The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services.

(b) The United States Food and Drug Administration.

(c) The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(d) The United States Department of Veteran’s Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(e) The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).

(f) The Centers for Disease Control and Prevention.

(g) The Agency for Health Care Research and Quality.

(h) The Centers for Medicare and Medicaid Services (CMS).

(i) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks.

(j) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(k) A qualified non-governmental research entity in guidelines issued by the National Institutes of Health for center support grants.

(2) A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.

(3) A study or investigation done for drug trials which are exempt from the investigational new drug application.

For purposes of this definition, the term "life threatening condition" means any disease or condition from which death is likely unless the disease of condition is treated.

Behavioral Health – a physical or behavioral condition having an emotional or psychological origin or effect, including substance abuse. Behavioral Health Services include mental health services and substance abuse services.

Benefits – your right to payment for Covered Services under this Contract subject to the terms, conditions, limitations, and exclusions of this Contract.

Child or Children – a child of the Subscriber or Subscriber's spouse, including any of the following until the Child attains the age of 26.

- Natural child,
- Stepchild,
- Legally adopted child,
- Child placed for the purpose of adoption, or
- Child placed under legal guardianship or legal custody.

Child includes a child of any age who is incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 26 and the Subscriber principally supports the Child. Proof of the disability must be submitted to us within thirty-one (31) days of the child's 26th birthday. For two years we may require proof of the child's continuing disability and dependency at reasonable intervals. After two years, we may require proof of the child's disability and dependency no more than once per year.

Coinsurance – a percentage of the Allowed Amount that you must pay for certain Covered Services. Coinsurance amounts are set forth in the Schedule of Benefits.

Contract – this individual contract issued by Indiana University Health Plans, Inc. which provides Benefits for Covered Services received by the Subscriber and enrolled Dependents. The term Contract includes the Schedule of Benefits, any application, amendments and riders.

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Copayment – a fixed amount you pay to a Provider for a Covered Service. The amount of a Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

Cosmetic Services – Health Care Services primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons.

Cost Sharing – the amount you are required to pay for Covered Services. Cost Sharing can be in the form of Copayments, Coinsurance or Deductibles.

Covered Person – you or any Dependent who meets all applicable eligibility requirements for coverage under this Contract, is enrolled as provided in this Contract, and for whom the required premium payment has been received by us.

Covered Services – Health Care Services performed, prescribed, directed or authorized by a Provider and for which this 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 this Contract is in force.
- Not experimental/investigative.
- Authorized in advance by us if Precertification is required under this Contract.
- Not excluded or limited by this Contract.

Deductible – the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The amount of the Deductible is set forth in the Schedule of Benefits.

Dependent – a person who is either the Subscriber's legal spouse or a Child.

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 [website] 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.

Durable Medical Equipment – Medical equipment that:

- can withstand repeated use and is not disposable,
- is used to serve a medical purpose,
- is generally not useful to a person in the absence of a Sickness or injury,
- is appropriate for use in the home, and
- is the most cost-effective type of medical apparatus appropriate for the condition.

Effective Date – the date when coverage under this Contract begins.

Emergency Medical Condition or Emergency – a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent 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 woman, the health of the woman or her unborn child) in serious jeopardy.

- Serious impairment to a person's bodily functions.
- Serious dysfunction of a bodily organ or part of a person.

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, 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, 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 woman 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 woman or the unborn child.

FDA – the United States Food and Drug Administration.

Grace Period – the time period for payment of premium set forth in Article 3 Section B.

Health Care Services – medical or health care services, whether or not covered under this 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.

Indiana Marketplace – the health benefit exchange established by the Affordable Care Act for the state of Indiana.

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

Medically Necessary – those Health Care Services that we determine to be all of the following.

(4) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for your illness, injury or disease.

(5) Required for the direct care and treatment or management of your illness, injury or disease.

(6) If not provided, your condition would be adversely affected.

(7) Provided in accordance with generally accepted standards of medical practice.

(8) Not primarily for the convenience of you, your family, the physician or another prescribing Provider.

(9) 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 your 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 your 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 used in this 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 – 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 this Contract.

Non-Participating Hospital – a Hospital that has not entered into a contractual agreement with us or is not otherwise engaged by us to provide Health Care Services to Covered Persons under this 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 Covered Persons under this Contract.

[**Open Enrollment Period** – the number of days each year during which individuals may enroll in a Qualified Health Plan through the Indiana Marketplace.]

[**Open Enrollment Period** – the number of days each year during which individuals may enroll for coverage under this Contract.]

Out of Pocket Maximum – the maximum amount you will pay for Covered Services in a Plan Year.

Outpatient – receipt of Health Care Services while not an Inpatient.

Participating Hospital – a Hospital 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 Covered Persons under this Contract.

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 Covered Persons under this Contract.

Plan Year – the calendar year during which this Contract is in effect. This Plan Year will be the 12 month calendar year except that if the Subscriber's Effective Date is after January 1st the Plan Year will begin on the Effective Date and end December 31st.

Precertification – 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.

Prescription Drug – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product, insulin, diabetic supplies, and syringes.

Prescription Legend Drug – A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

Primary Care Physician or 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 your medical care under this Contract.

Provider – a doctor, Hospital, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

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.

(1) The Health Care Service that is the subject of the Approved Clinical Trial.

(2) 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.

(3) 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.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) 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.

(6) A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.

(7) A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Qualified Health Plan – a health plan offered on the Indiana Marketplace that satisfies the requirements set forth under the Affordable Care Act (42 U.S.C. 18021(a)(1)).

[**Qualified Individual** – an individual who has been determined by the Indiana Marketplace to be eligible to enroll in a Qualified Health Plan.]

Schedule of Benefits – the part of this Contract that sets forth Cost Sharing, Out of Pocket Maximums, limitations and other information regarding your coverage under this Contract.

Service Area – the counties in which we are authorized to offer a qualified health plan. Our Service Area is [insert list of counties].

Sickness – a physical illness, disorder, or disease.

Deleted: Sickness does not include Behavioral Health conditions.

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.

[**Special Enrollment Periods** – enrollment periods administered by the Indiana Marketplace that occur outside of the Open Enrollment Period. Qualified Individuals and their dependents who are eligible for a Special Enrollment Period may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another during a Special Enrollment Period set for them by the Indiana Marketplace.]

[**Special Enrollment Periods** – enrollment periods administered by us that occur outside of the Open Enrollment Period.]

Spouse – the Subscriber's legal spouse.

Therapeutic Abortion – an abortion performed to save the life or health of the mother, or as a result of incest or rape

Urgent Care Claim – 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 your life, health or ability to reach and maintain maximum function.

- In the opinion of physicians familiar with your condition, would subject you to severe pain that cannot be adequately managed unless we approve the Claim.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT.

[This Contract is available through the Indiana Marketplace. The Benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Indiana Marketplace to be Qualified Individuals.]

A. **You as an Individual:** To be eligible for coverage as a Subscriber, an individual must meet the eligibility requirements listed below at the time of application and throughout the Plan Year.

(1) [Determined by the Indiana Marketplace to be a Qualified Individual for purposes of enrollment in a Qualified Health Plan.] [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective.]

(2) [Not incarcerated.] [Agree to pay the cost of the Premium that we require.]

(3) [A United States citizen or lawfully present non-citizen.] [Submit proof satisfactory to us to confirm Dependent eligibility.]

(4) A resident of the State of Indiana.

(5) Not entitled to or enrolled in Medicare or Medicaid.

(6) Not covered by any other group or individual health benefit plan.

B. **Your Dependents:** To be eligible as a Dependent, another person must either be your Spouse or your Child.

C. [**Other Rules About Eligibility.** No one will be denied enrollment or re-enrollment in this Contract because of health status, or the existence of a pre-existing physical or mental condition.]

D. **Open Enrollment**.

(1) [Notice of Annual Open Enrollment. Each calendar year the Indiana Marketplace will provide you with a written annual open enrollment notification no earlier than September 1, and no later than September 30.]

[Notice of Annual Open Enrollment. Each calendar year we will provide you with a prior written notice of the Open Enrollment Period.]

(2) [2015 Open Enrollment Period. For this Plan Year beginning on January 1, 2015, the Open Enrollment period begins on November 15, 2014 and extends through February 15, 2015.]

(3) [Effective Dates for Coverage Selected During 2015 Open Enrollment. For this Plan Year beginning on January 1, 2015, the following Effective Dates will apply:

(a) January 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace on or before December 15, 2014.

(b) February 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from December 16, 2014 through January 15, 2015.

(c) March 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from January 16, 2015 through February 15, 2015.]

(4) [Effective Dates for Coverage Selected During Annual Open Enrollment. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if we receive the application and initial premium payment between the 1st and 15th of the month. If we receive the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st)]

E. [**Special Enrollment Period.**

(1) Special Enrollment Triggering Events. The Indiana Marketplace must allow Qualified Individuals and their Dependents to enroll in a Qualified Health Plan or change from one Qualified Health Plan to another as a result of experiencing any of the following triggering events:

(a) Loss of Minimum Essential Coverage.

(b) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(c) Gaining status as a citizen, national, or lawfully present individual.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services ("HHS"), or its instrumentalities as evaluated and determined by the Indiana Marketplace. In such cases, the Indiana Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to a new service area of the Indiana Marketplace.

(h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(i) Demonstration to the Indiana Marketplace, in accordance with guidelines issued by HHS, that you or your Dependent meets other exceptional circumstances as the Indiana Marketplace may provide.

(j) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.)

(2) Indiana Marketplace Administration of Special Enrollments. For additional information on special enrollment triggering events and how to enroll in or change a Qualified Health Plan during a Special Enrollment Period, you should contact the Indiana Marketplace at [toll free number] or visit the Indiana Marketplace website at [www.healthcare.gov].

(3) Notice Requirement for Special Enrollments. Unless specifically stated otherwise in the applicable Indiana Marketplace rules, a Qualified Individual or Dependent has sixty (60) days from the date of a special enrollment triggering event to select a Qualified Health Plan.

(4) Special Enrollment Effective Dates. The Effective Date for coverage obtained under this Contract during a Special Enrollment Period depends on the type of triggering event that qualified the individual and/or dependent for the Special Enrollment Period as well as the date the Indiana Marketplace received the Qualified Individual's Qualified Health Plan selection.

(a) For a Qualified Health Plan selection received from the first (1st) through the fifteenth (15th) day of any month, the Effective Date will be the first (1st) day of the following month; and

(b) For a Qualified Health Plan selection received from the sixteenth (16th) through the last day of any month, the Effective Date will be the first (1st) day of the second following month.]

E. [**Changes Affecting Eligibility and Special Enrollment Periods.**

(1) Special Enrollment Triggering Events. A Special Enrollment Period is a period during which an eligible individual who experiences certain triggering events or changes in eligibility may enroll in this Contract, outside of the Open Enrollment period.

(2) Length of Special Enrollment Period. Unless otherwise stated, an eligible individual has 60 days from the date of a triggering event to enroll an eligible individual in this Contract.

(3) Triggering Events

(a) Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, misrepresentation of a material fact or failure to pay premium.

(b) Loss of Minimum Essential Coverage due to dissolution of marriage.

(c) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Indiana Marketplace.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to new service area of the Indiana Marketplace.

(h) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.]

F. Adding New Dependents Under A Special Enrollment Period

(1) Newly Born Children. If you have a new Dependent as a result of birth, coverage for your new Dependent is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for your new Dependent shall continue beyond the initial thirty-one (31) days, provided you [request a Special Enrollment Period through the Indiana Marketplace to add your new Dependent to this Contract] [submit a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, if any[, within 60 days after the birth of the new Dependent]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days after the date of birth. The Effective Date will be the date of birth.]

(2) Adopted Children. If you have a new Dependent as a result of adoption, coverage for your new Dependent is automatically provided from the earlier of

the date of placement for the purpose of adoption or the date of the entry of an order granting you custody of the child for purposes of adoption, for up to thirty-one (31) days. Coverage for your new Dependent shall continue beyond the initial thirty-one (31) day period provided you [request a Special Enrollment Period through the Indiana Marketplace to add your new Dependent to this Contract] [submit a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, in any[, within 60 days following the date of adoption or placement for adoption]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of adoption or placement of adoption.] The Effective Date will be the earlier of the date of adoption or placement of adoption.

(3) Adding a Child due to Award of Guardianship. If you or your spouse files an application for an appointment of guardianship for a Child, an application to cover the Child under this Contract must be submitted to [the Indiana Marketplace] [us] within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

(4) Qualified Medical Child Support Order. If you are required by a Qualified Child Support Order or court order, as defined by applicable state and federal law, to enroll your Child under this Contract, and the Child is otherwise eligible for the coverage, [the Indiana Marketplace] [we] will permit your Child to enroll in this Contract, and we will provide the benefits of this Contract in accordance with the applicable requirements of such court order.

A Child's coverage under this provision will not extend beyond the Dependent attaining age 26. Any claims payable under this Contract will be paid, at our discretion, to the Child or the Child's custodial parent or legal guardian, for any expenses paid by the Child, custodial parent or legal guardian. We will make information available to the Child, custodial parent or legal guardian on how to obtain benefits and submit claims to us directly.

(5) Spouse or Loss of Minimum Essential Coverage. If you have a new Dependent as a result of marriage, or due to your new Dependent's loss of Minimum Essential Coverage, you may elect to enroll your new Dependent in this Contract, provided you [request a Special Enrollment Period from the Indiana Marketplace to add your new Dependent to this Contract] [submit to us a form to add your new Dependent] and we receive payment for additional applicable premium, if any[, within 60 days from the date of marriage or the loss of Minimum Essential Coverage]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of marriage or the loss of Minimum Essential Coverage.] The Effective Date will be on the first (1st) day of the month following the date of marriage or loss of Minimum Essential coverage.

(a) "Loss of Minimum Essential Coverage" includes loss of eligibility for coverage as a result of any of the following:

(a) Legal separation or divorce.

(b) Cessation of dependent status (such as reaching the maximum age to be eligible as a Dependent under this Contract).

(c) Death of an employee; termination of employment; reduction in the number of hours of employment; or any loss of eligibility for coverage after a period that is measured by any of the foregoing.

(d) Individual who no longer resides, lives or works in the service area.

(e) A situation in which a health benefit plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Termination of employer contributions.

(g) Exhaustion of COBRA continuation of coverage.

(b) "Loss of Minimum Essential Coverage" does not include termination or loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(b) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact

If you do not enroll your new Dependent during the time periods stated above, he or she will not be added to your coverage until the next Open Enrollment Period.

G. Notification of Changes.

(1) Responsibility to Notify [the Indiana Marketplace] [Us]. You are required to notify [the Indiana Marketplace] [us] of any changes in your eligibility or the eligibility of your Dependents for Benefits under this Contract. [The Indiana Marketplace] [We] must be notified of any changes in eligibility as soon as possible, but not later than thirty (30) days from the date of the change in eligibility status. This may include changes in address, marriage, divorce, death, incarceration, change of Dependent disability or dependency status, change in Medicare or Medicaid eligibility status, etc. Notice of a change in eligibility must be provided to [the Indiana Marketplace in a form required and approved by the Indiana Marketplace] [us in writing and on a form approved by us]. Such notifications must include all information required to effectuate all necessary changes.

(2) Failure to Notify [Indiana Marketplace] [Us]. Failure to notify [the Indiana Marketplace] [us] of persons no longer eligible for coverage under this Contract will not obligate us to provide services to those no longer eligible. Our acceptance of payments for persons no longer eligible for services will not obligate us to pay for such services.

(3) Effective Date of Termination Due to Change in Eligibility. Regardless of whether we receive timely notice, a Covered Person's coverage will terminate on the [last day of the month following the date] [day] such Covered Person ceases to be eligible for coverage under this Contract. [We have the right to bill you for the cost of any Health Care Services provided to a Covered Person during the period such Covered Person is not eligible under this Contract.] If you think there are reasons coverage of the person experiencing the change should continue, you must notify [the Indiana Marketplace] [us] of the reasons for the continuation of the coverage no later than thirty-one (31) days after the date coverage for the Dependent would otherwise terminate.

(4) [Statements and Forms. You shall complete and submit to us applications and other forms or statements we may request. You represent to the best of their knowledge and belief that all information contained in such applications, forms, questionnaires, and statements submitted to us is true, correct and complete. You understand that all rights to Benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you or a Covered Person may result in termination or rescission of coverage.]

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A. Premium

(1) You must pay premium to us each month for coverage under this Contract. Your premium rate is determined using the following acceptable rating factors: age, tobacco use, family size and geography.

(a) Tobacco use impacts the determination of your premium. [Upon enrollment through the Indiana Marketplace] [During the enrollment application process], you will attest to tobacco use by you and/or your Dependents. If you report false or incorrect information about tobacco use, we may retroactively apply the appropriate tobacco rating factor to your premium as if the correct information had been accurately reported from the Effective Date.

(b) Your age impacts the determination of your premium rate. If your age has been misstated, we will adjust the premiums to the amount premiums would have been if purchased at the correct age.

(2) You will receive a monthly bill for your premium. Your payment is due by the date stated in your bill subject to the any applicable Grace Period stated in this Contract. You must pay your premium when it is due for coverage to continue.

(3) We reserve the right to change the premium on an annual basis. We will provide you with thirty (30) days prior written notice of any change in the premium.

(4) Your premium may change if Dependents are enrolled or disenrolled in your coverage. If a premium increase is necessary, we will bill you for the additional amount due. If this amount is not paid, this Contract will be cancelled at the end of the applicable Grace Period and you will receive a refund of any unearned premium. If a decrease in premium is appropriate we will notify you of the decrease and refund any excess premium to you.

(5) If premium has been paid for any period of time after the date you cancel this Contract, we will refund that premium to you. The refund will be for the period of time after your coverage ends. If a Covered Person dies while this Contract is in force, we will refund any premium paid for such Covered Person for any period after the date of the Covered Person's death to you or your estate.

B. Grace Period

(1) [General Grace Period.] Following payment of the initial premium, a Grace Period of thirty (30) days shall be granted for the payment of any premium. This Grace Period shall not extend beyond the date this Contract terminates. During the Grace Period this Contract shall continue in force. Any claims incurred and submitted during the Grace Period will not be considered for payment until premium is received. If premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of coverage.

(2) [Grace Period for Persons Receiving Advance Payments of the Premium Tax Credit. If you are receiving advance payments of the premium tax credit and at least one full month's premium has been paid during this Plan Year, a Grace Period of three (3) consecutive months shall be granted for the payment of any premium. During this 3-month Grace Period, we shall do all of the following listed below.

(a) Pay for Covered Services during the first (1st) month of the Grace Period and may pend claims for Covered Services rendered to you in the second and third months of the Grace Period.

(b) Notify the Department of Health and Human Services of such non-payment

(c) Notify Providers of the possibility for denied claims during the second and third months of the Grace Period.]

C. Deductible.

(1) The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The Deductible is set forth in the Schedule of Benefits.

(2) Copayments do not count towards the Deductible.

D. Coinsurance

(1) Coinsurance is a percentage of the Allowed Amount that you must pay for Covered Services. You are responsible for payment of Coinsurance after you have met the Deductible and until you reach the Out of Pocket Maximum. Coinsurance is set forth in the Schedule of Benefits.

(2) Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

E. Copayments

(1) Copayments are a fixed amount you pay to a Provider for a Covered Service. Copayments are typically paid when you receive the Covered Service. The amount of the Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

(2) Copayments do not apply to the Deductible. Copayments apply towards the Out of Pocket Maximum.

F. Out of Pocket Maximum

(1) The Out of Pocket Maximum is the maximum amount you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum is listed on the Schedule of Benefits.

(2) Once the Out of Pocket Maximum is reached, we will pay 100% of the Benefits for Covered Services.

(3) Copayments, Coinsurance and the Deductible apply towards the Out of Pocket Maximum.

G. Payments for Non-Covered Services. You are responsible for payment of all expenses for Non-Covered Services.

ARTICLE 4. COVERED SERVICES

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides Benefits for the following Covered Services. Payment for Covered Services is limited by any applicable Coinsurance, Copayment, or Deductible set forth in this Contract including the Schedule of Benefits. To receive maximum Benefits for Covered Services, you must follow the terms of this Contract, including receipt of care from a Primary Care Physician and Participating Providers as well as obtaining any required Precertification.

You are responsible for all expenses incurred for Non-Covered Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

A. Ambulance Services

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

(a) From your home, scene of accident or medical Emergency to a Hospital,

(b) Between Hospitals,

(c) Between a Hospital and Skilled Nursing Facility, or

(d) From a Hospital or Skilled Nursing Facility to your home.

(2) Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

(3) Other vehicles which do not meet the definition of Ambulance Services are not Covered Services. Ambulette services are Covered Services when appropriate.

(4) Ambulance Services are a Covered Service only when Medically Necessary, except:

(a) When ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse, or

(b) When a Covered Person is required by us to move from a Non-Participating Provider to a Participating Provider.

(5) Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health.

(6) Non-Covered Services for Ambulance include but are not limited to:

(a) A trip to a physician's office or clinic,

(b) A trip to a morgue or funeral home, or

(c) Any ambulance usage for the convenience of a Covered Person, family or Provider.

B. Behavioral Health Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Covered Services include:

(a) Inpatient services. Individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

(b) Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

(c) Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health conditions. Intensive Outpatient programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient programs may offer group, DBT, individual, and family services.

(d) Outpatient Treatment, or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

(2) Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

(3) To assist you in obtaining appropriate and quality care, we will ask for a treatment plan after you have been evaluated after 10 Outpatient visits. We may discuss the goals of treatment and changes in the treatment plan, including

alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

(4) Non-Covered Services include the following.

(a) Custodial or domiciliary care.

(b) Supervised living or halfway houses.

(c) Services or care provided or billed by a residential treatment center, school, halfway house.

(d) Custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(e) Services related to non-compliance of care if the Covered Person ends treatment for substance abuse against the medical advice of the Provider.

C. Routine Care Costs as Part of a Cancer or Other Life Threatening Disease or Condition Clinical Trial

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits are available for Routine Care Costs rendered as part of an Approved Clinical Trial if the services are otherwise Covered Services under this Contract.

(2) Your Primary Care Physician must give us notice of your participation in an Approved Clinical Trial.

(2) Non-Covered Services include the following.

(a) A Health Care Service that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient.

(b) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service or investigational drug that is the subject of the clinical trial.

(c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.

(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the clinical trial.

(e) An item or drug provided by the clinical trial sponsors free of charge for any patient.

(f) A service, item, or drug that is eligible for reimbursement by a person or entity other than us, including the sponsor of the clinical trial.

D. Dental Services Related to an Injury

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient services, Physician Home Visits and Office Services, Emergency Services and Urgent Care Center Services for dental work and oral surgery are Covered Services if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Covered Person's condition.

(2) Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

(3) For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

(4) Covered Services include, but are not limited to the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations
- Prosthetic services
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia

(5) Anesthesia and Hospital charges for dental care for a Covered Person less than 19 years of age or a Covered Person who is physically or mentally disabled, are covered if the Covered Person requires dental treatment to be given in a Hospital or Outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Covered Person's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

E. Diabetic Equipment, Education and Supplies

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when ordered in writing by a physician or a podiatrist and provided by a physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

(2) Covered Services include physician prescribed equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical Equipment and Appliances", "Preventive Care Services", and "Physician Home Visits and Office Services".

F. Diagnostic Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services include the following.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).

- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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

(3) For Diagnostic services other than those approved to be received in a physician's office, you may be required to use a laboratory that is a Participating Provider.

(4) When Diagnostic radiology is performed in a Participating Provider's Office, no Copayment is required, however, any Coinsurance will still apply.

G. Emergency Care Services and Urgent Care Center Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit limitation. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits for treatment of an Emergency Medical Condition and Emergency screening and stabilization services without Precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions.

(2) Benefits for Emergency Care include facility costs and physician services, supplies and Prescription Drugs charged by that facility.

(3) Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Copayment or Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify us or verify that your physician has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary. If your Provider is a Non-Participating Provider, you will be financially responsible for any care we determine is not Medically Necessary.

(4) Often an urgent rather than an Emergency Medical Condition exists. An urgent medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Such medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Primary Care Physician prior to receiving care for an urgent medical problem and your Primary Care Physician

authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Care Services.

H. Home Care Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Covered Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Care Services.
- Nutritional Guidance.
- Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Health Care Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Care Services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services in the home (except for Massage, Music, and Manipulation Therapy). Home Care visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

(3) Non Covered Services include the following.

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

(4) Home infusion therapy will be paid only if you obtain Precertification. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

I. Hospice Services

For all Covered Services, see the schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit limitations. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) 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 (6) months or less, as certified by the attending physician and hospice medical director. Covered Services will continue if the Covered Person lives longer than six (6) months, provided the hospice medical director or other hospice physician recertifies that the Covered Person is terminally ill.

(2) Covered Hospice Services include the following.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Care Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

(3) Non-Covered Services include services provided by volunteers and housekeeping services.

J. Inpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Inpatient services include the following.

(a) Charges from a Hospital, Skilled Nursing Facility or other Provider for room, board and general nursing services.

(b) Ancillary services.

(c) Professional services from a physician while an Inpatient.

(2) Room, Board, and General Nursing Services include either of the following.

(a) A room with two or more beds or a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

(b) A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

(3) Ancillary (Related) Services include any of the following.

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

(4) Professional Services include the following.

- Medical care visits limited to one visit per day by any one physician.
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, and EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

(5) When a Covered Person is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

K. Maternity Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

(2) If the Covered Person is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider for the Health Care Services to be Covered Services. If the Covered Person is pregnant on her Effective Date and is in her second or third trimester of pregnancy, she may receive Benefits for Health Care Services from a Non-Participating Provider if she requests and receives written approval from us.

(3) If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance or Copayment.

(4) If Maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

(5) Coverage for the Inpatient postpartum stay for a Covered Person and her newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if both or the following are met.

(a) In the opinion of your attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the following.

- The antepartum, intrapartum, and postpartum course of the mother and infant.
- The gestational stage, birth weight, and clinical condition of the infant.
- The demonstrated ability of the mother to care for the infant after discharge.
- The availability of post discharge follow-up to verify the condition of the infant after discharge.

(b) The mother of the newborn child agrees with the recommendation for a shorter length of stay.

(6) Covered Services include at-home post-delivery care visits at your residence by a physician or nurse performed no later than 48 hours following discharge from the Hospital. Coverage for this visit includes, but is not limited to parent education, assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At your discretion, this visit may occur at the physician's office.

(7) Covered Services include the following tests and examinations given at the earliest feasible time to the newborn child for the detection of the following disorders.

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

L. Medical Supplies, Durable Medical Equipment and Appliances

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Medical and Surgical Supplies. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a physician's office, including but not limited to, Depo-Provera and Remicade. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

(a) Covered Services include the following.

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.

- Clinitest.
- Needles/syringes.
- Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not Covered Services.

(b) Non-Covered Services include the following.

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Medijectors.

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

(3) Durable Medical Equipment - The rental (or, at our option, the purchase) of Durable Medical Equipment prescribed by a Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples of Durable Medical Equipment include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price.

(a) We will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Covered Person, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is a Covered Service.

(b) Covered Services include the following.

- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pump for IV fluids and medicine.
- Glucometer.

- Tracheotomy tube.
- Cardiac, neonatal and sleep apnea monitors.
- Augmentive communication devices are Covered Services when we approve based on the Covered Person's condition.
- CPAP machines when indicated for sleep apnea.

(c) Non-Covered Services include the following.

- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats.
- Rental of equipment if the Covered Person is in a Facility that is expected to provide such equipment.
- Translift chairs.
- Treadmill exerciser.
- Tub chair used in shower.

(4) Prosthetics. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

(a) Prosthetic devices should be purchased not rented. Applicable taxes, shipping and handling are Covered Services.

(b) Covered Services include the following.

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Plan Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction

is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered Services. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be a Covered Service.

- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Plan Year).

(c) Non-Covered Services include the following.

- Dentures, replacing teeth or structures directly supporting teeth.
- 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.

(5) Orthotic Devices. The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered Services. The casting is a Covered Service when an orthotic appliance is billed with it, but not if billed separately.

(a) Covered Services include the following.

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

(b) Orthotic appliances may be replaced one time per Plan Year unless specifically approved in writing by us. Additional replacements will be allowed for Covered Persons under age 18 due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

(c) Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

(d) Non-Covered Services include the following.

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

(6) Prosthetic limbs & Orthotic custom fabricated brace or support. Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be a Covered Service if they are determined by your physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities, and are not solely for comfort or convenience.

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

(b) Prosthetic limbs and orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

(7) Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below, as approved by us.

(a) The repair, adjustment or replacement of the purchased equipment, supply or appliance is a Covered Service if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.

- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

(b) Replacement of purchased equipment, supplies or appliance may be a Covered Service if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

(c) Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

M. Outpatient Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital or other facility as determined by us. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation.

(2) Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to Article 3 Section B for Behavioral Health Services covered by this Contract.

(3) Professional charges only include services billed by a physician or other professional.

(4) When Diagnostic Services or other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Service, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

(5) For Emergency Care refer to the section titled Emergency Services.

N. Autism Spectrum Disorder Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Autism Spectrum Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(2) Coverage is provided for the treatment of Autism Spectrum Disorders, including behavioral therapies such as Applied Behavior Analysis (ABA). Benefits are limited to Health Care Services prescribed by your physician in accordance with a treatment plan. Coverage for Health Care Services will be provided as prescribed by your treating physician in accordance with the treatment plan.

(3) Any exclusion or limitation in this Contract in conflict with the coverage described in this section will not apply.

(4) Coverage for Autism Spectrum Disorders will not be subject to limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Contract.

O. Physician Home Visits and Office Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service a Health Care Service must be Medically Necessary.

(1) Covered Services include care provided by a physician, including employees of the physician such as an advanced practice nurse or physician assistant, in his/her office or your home. Refer to the sections titled Preventive Care, Maternity Care, Home Care Services, and Behavioral Health Care Services for services covered by this Contract. For Emergency Care refer to the Emergency Services section.

(2) Office visits for medical care and consultations to examine, diagnose, and treat a Sickness or injury performed in the physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a physician's office, no Copayment is required however Coinsurance will apply.

(3) Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

(4) Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

(5) Surgery and surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

(6) Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a physician or other professional Provider.

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

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

(2) Preventive Care Services in this section shall meet requirements as determined by federal and state law.

(a) Health Care Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF. Covered Services include the screenings for following.

- Breast cancer.
- Cervical cancer.
- Colorectal cancer.
- High Blood Pressure.
- Type 2 Diabetes Mellitus.
- Cholesterol.
- Child and Adult Obesity.
- For Covered Persons age 15 – 65 and other ages at increased risk, Human Immunodeficiency Virus (HIV)
- Depression for adults
- Screening for alcohol misuse

(b) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(c) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Well Baby visits and care.
- Newborn screening for hearing
- Lead screening for children at risk for exposure
- Depression screening for adolescents

(d) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Women's contraceptives, sterilization procedures, and counseling. This includes generic drugs only, unless there is no generic equivalent, obtained from a Participating Pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms and intrauterine devices (IUDs) are also covered. When generic equivalents are available, prescription brand name contraceptives will not be covered under the Preventive Care benefit. Instead, prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the Prescription Drug Benefits section.
- Breastfeeding support, supplies, and counseling.
- Gestational diabetes screening.

(3) Covered Services also include the following services required by state law:

(a) Breast Cancer Screening. The following are Covered Services.

(a) If the female Covered Person is at least 35 years of age, one (1) baseline breast cancer screening mammography performed before she becomes 40 years of age.

(b) If the female Covered Person is less than 40 years of age and is high risk, one (1) breast cancer screening mammography performed every year. A woman is considered "high risk" if she meets at least one (1) of the following.

(A) Has a personal history of breast cancer.

(B) Has a personal history of breast disease proven benign by biopsy.

(C) Has a mother, sister, or daughter who has had breast cancer.

(D) Is at least 30 years of age and has not given birth.

(c) Any additional mammography views that are required for proper evaluation.

(d) Ultrasound services, if determined Medically Necessary by the physician treating the Covered Person.

(b) Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Service for a Covered Person under the age of fifty (50) if the Covered Person is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsymptomatic Covered Person, in accordance with the current American Cancer Society guidelines.

(c) Diagnostic Prostate Cancer Screening. If male Covered Person is at least 50 years of age, one (1) prostate specific antigen test annually is a Covered Service. If a male Covered Person is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test annually is a Covered Service.

Q. Surgical Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes the following.

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

(2) The surgical fee includes normal post-operative care.

(3) We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact us for more information.

(4) Covered Surgical Services include the following.

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

R. Reconstructive Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

(2) Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract.

(3) Covered Services are limited to the following.

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

(4) For a Covered Person who has undergone a mastectomy Covered Services include the following.

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

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Deleted: or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive coverage for

S. Sterilization.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

Sterilization is a Covered Service.

T. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

(2) Covered Services include removable appliances for repositioning and related surgery, medical care, and diagnostic services.

(3) Non-Covered Services include the following:

- Fixed or removable appliances that involve movement or repositioning of the teeth.
- Repair of teeth (fillings).
- Prosthetics (crowns, bridges, dentures).

U. Therapy Services.

Benefits are provided for therapy services that can be Rehabilitative or Habilitative. For purposes of this section and the Schedule of Benefits, the following definitions apply:

- Rehabilitation refers to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech therapy and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Physical therapy.

(a) Physical therapy includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve

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

(b) Non-Covered Services include the following.

-
- 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.

Deleted: Maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness.

(3) Speech Therapy. Speech therapy for the correction of a speech impairment.

(4) Occupational Therapy. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

(a) Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

(b) Non-Covered Services include the following.

- Supplies (looms, ceramic tiles, leather, utensils).
- Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again.
- General exercises to promote overall fitness and flexibility.
- Therapy to improve motivation.
- Suction therapy for newborns (feeding machines).
- Soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial.
- Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

(5) Manipulation Therapy. Manipulation Therapy includes osteopathic/chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

(a) Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any limitation for Manipulation Therapy services as specified in the Schedule of Benefits.

(b) Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

(6) Other Therapy Services

(a) Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

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

(c) Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage this Contract will not require you to receive dialysis treatment at a Participating Provider that is a dialysis facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Participating Dialysis Facility is more than 30 miles from your home, you may, upon our prior written consent, receive treatment at a Non-Participating Provider that is a dialysis facility nearest to your home as Covered Service.

(d) Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

(e) Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to:

- Introduction of dry or moist gases into the lungs.
- Nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication.
- Continuous positive airway pressure ventilation (CPAP).
- Continuous negative pressure ventilation (CNP).
- Chest percussion.
- Therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers.
- Broncho-pulmonary drainage.
- Breathing exercises.

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

V. Physical Medicine and Rehabilitation Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

(2) The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting. Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

(3) Non-Covered Services include the following.

- Admission to a Hospital mainly for physical therapy.
- Long term rehabilitation in an Inpatient setting.

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

W. Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Cost Sharing.

(2) "Covered Transplant Procedure" includes any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

(3) "Transplant Benefit Period" starts one day prior to a covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Procedure and continues to the date of discharge at a Non-Participating Provider Facility.

(4) Transplant services require Precertification.

(5) Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are a Covered Service as routine Diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

(6) Transportation and Lodging. This Contract will provide assistance with reasonable and necessary travel expenses as determined by us when you obtain Precertification and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when claims are filed.

(7) Non-Covered Services for transportation and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

X. Prescription Drug Benefits

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Pharmacy Benefits Manager (PBM).

(a) The Prescription Drug benefits are managed by our Pharmacy Benefits Manager or PBM. The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy, a Specialty Pharmacy, and provides clinical management services. The management and other services the PBM provides include, making recommendations to, and updating, the “covered Prescription Drug list” (the “covered Prescription Drug list” is referred to as the “Formulary”), managing a network of retail pharmacies, operating a mail service pharmacy, and operating a Specialty Pharmacy network.

(b) The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of Prescription Drug benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions or drug/pregnancy concerns. You may request a copy of the Formulary by calling the Customer Service telephone number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage.

(c) For certain Prescription Drugs, the prescribing Provider may be asked to provide additional information before the PBM and/or we can determine Medical Necessity. We may, in our sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer.

(d) Precertification may be required for certain Prescription Drugs (or the prescribed quantity of a particular Prescription Drug). At the time you fill a prescription, the Participating Pharmacy is informed of the Precertification requirement through the Participating Pharmacy's computer system. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee which is reviewed and adopted by us.

(e) For a list of the current Prescription Drugs requiring Precertification, please contact the Customer Service telephone number on the back of your Identification Card or go to our website at [insert url to formulary]. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage. Your Provider or Participating Pharmacy may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under this Contract.

(2) Therapeutic Substitution of Prescription Drugs. This is a voluntary program designed to inform Covered Persons and Providers about possible substitutes to certain Prescription Drugs. We, or the PBM, may contact you and your prescribing Provider to make you aware of substitution options. Therapeutic substitutes may also be initiated at the time the Prescription Drug is dispensed.

(a) Only you and your Provider can determine whether the therapeutic substitute is appropriate for you.

(b) For questions or issues involving therapeutic substitutes, call the Customer Service telephone number on the back of your Identification Card.

(c) The therapeutic substitutes list is subject to periodic review and amendment.

(3) Step Therapy. Step therapy protocol means that a Covered Person may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Covered Persons access high quality yet cost effective Prescription Drugs. If a Provider decides that the monitored medication is needed the Precertification process is applied.

(4) Participating Specialty Pharmacy. The PBM's Specialty Pharmacy is available to Covered Persons who use Specialty Drugs.

(a) "Specialty Drugs" are Prescription Legend Drugs that are one of the following:

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

(b) Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, subject to a day supply limit for retail and mail service, and the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

(c) Questions regarding Specialty Drugs can be directed to the Customer Service telephone number on the back of your Identification Card.

(d) You may obtain a list of the Participating Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your Identification Card, or review the lists on our website at [insert address].

(5) Covered Services include the following.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Self-administered contraceptives, including oral contraceptives, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the Preventive Care section, please see that section for more details.
- Selected drugs to eliminate or reduce dependence on, or addiction to tobacco and tobacco products.
- Injectables.
- Selected preventive medications are covered with no Copayment or Coinsurance if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations. These medications include the following: vitamin D supplementation, folic acid supplementation, aspirin and oral fluoride supplementation.

(6) In addition to the Exclusions set forth in Article 4, Non-Covered Services include the following.

- Prescription Drugs dispensed by any mail service program other than the PBM's mail service pharmacy, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.

- Off label use, except as otherwise prohibited by law or as approved by us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription.
- Drugs not approved by the FDA except as otherwise prohibited by law.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a physician. This does not apply to drugs used in conjunction with a Diagnostic Service, with chemotherapy performed in the office or drugs eligible for coverage under the Medical Supplies benefit.
- Any drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by this Contract, or which exceed any age limits established by us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility drugs.
- Human growth hormone for children born small for gestational age.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact us for additional information on these Prescription Legend Drugs.
- Refills of lost or stolen medications.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, unless otherwise required by law or approved by us. "Clinically equivalent" means drugs that, for the majority of persons, can be expected to produce similar therapeutic outcomes for a disease or condition.

(7) If you have questions regarding whether a particular Prescription Drug is covered and which Tier a Prescription Drugs fall into, please call the Customer Service telephone number on the back of your Identification Card, or visit our website at [website address].

(8) Each Prescription Drug may be subject to a Deductible, Coinsurance or Copayment. If the prescription includes more than one covered Prescription Drug, a separate Coinsurance or Copayment will apply to each covered Prescription Drug. Your Copayment will be the lesser of your scheduled Copayment or the Allowable Amount.

(9) The number of days' supply of a Prescription Drug which you may receive is limited. The days' supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days' supply allowed for under this Contract, you should ask your Pharmacist

to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

(10) Your Copayment or Coinsurance amount may vary based on whether the Prescription Drug has been classified by us as a first, second, third, fourth or fifth "Tier" Prescription Drug. The determination of Tiers is made by us based upon clinical information, and where appropriate the cost of the Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

(a) Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This Tier will contain low cost and preferred generic medications as well as selected preventive medications that are covered with no Coinsurance or Copayment if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations.

(b) Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This Tier will contain non-preferred generic medications.

(c) Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This Tier will contain preferred brand name medications.

(d) Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This Tier will contain non-preferred brand name medications.

(e) Tier 5 Prescription Drugs will have a higher/comparative Coinsurance or Copayment than those in Tier 4. This Tier will contain medications that are considered Specialty Drugs.

We have established a Pharmacy and Therapeutics Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Precertification criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives. The Pharmacy and Therapeutics Committee also determines, where appropriate, the cost of a Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one drug over another in our patient program, and, where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by

mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

(11) From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, generic, mail service, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Prescription Drugs or preferred products for a limited period of time.

(12) The amount of Benefits paid is based upon whether you receive the Covered Services from a Participating Pharmacy, including a Participating Specialty Pharmacy, a Non-Participating Pharmacy, or the PBM's mail service program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug.

(13) How you obtain your Benefits depends upon whether you go to a Participating or a Non-Participating Pharmacy.

(a) Participating Pharmacy – Present your written prescription from your physician and your Identification Card to the pharmacist at a Participating Pharmacy. The Participating Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment or Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge and you believe the Prescription Drug should be covered, ask your pharmacist for an itemized receipt and submit it to us for reimbursement consideration.

(b) Specialty Drugs - You or your Provider can order your Specialty Drugs directly from a Participating Specialty Pharmacy, simply call the Customer Service telephone number on the back of your Identification Card. Your Specialty Drug may need Precertification prior to dispensing. Upon approval, your Specialty Drug will be delivered to your physician's office/your specified delivery location based on the physician's order. A clinician will be available to answer any questions you may have in regard to the Specialty Drug and the instructions.

(c) Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy, including a Non-Participating Specialty Pharmacy. You must submit a claim for reimbursement consideration as set forth in Article 8 Section C.

(d) The Mail Service Program – Complete the order and patient profile form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have your physician fax the prescription to the mail service pharmacy. Your physician may also phone in the prescription to the mail service pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the mail service pharmacy when you request a prescription.

(14) Drug Exception Program. This is a program designed to allow Covered Persons to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. Please call the Customer Service number on the back of your Identification Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or are currently undergoing a course of treatment using a Prescription Drug that is not on the Formulary, you may request an expedited review of your request for a drug exception. In such circumstances, we will provide you or your Designated Representative with our decision within twenty-four (24) hours after we receive your request.

Deleted: The Drug Exception Program is separate from and in addition to the benefit review and appeals processes outlined in Article 7.

Y. Pediatric Vision Services. The following Health Care Services are Covered Services only for Covered Person through the age of nineteen (19). The Contract only provides Benefits for vision care that is listed in this section.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A complete pediatric eye exam. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together. The exam may include the following.

- Case History.
- Cover test.
- Ocular Motility.
- Neurological Integrity.
- External Exam.
- Internal Exam.
- Retinoscopy.
- Phorometry testing.
- Point refraction.
- Tonometry.
- Opthalmoscopic exam.
- Confrontation Visual Fields.
- Biomicroscopy.
- Color Vision Testing.
- Diagnosis/Prognosis.
- Recommendations.

(2) Eyeglass Lenses. Lens options include a choice of plastic or polycarbonate. Lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include up to 55 mm in single vision, bifocal, trifocal or lenticular.

(3) Frames. This Contract offers a selection of frames that are covered.

(4) Contact Lenses. Coverage includes the following.

(a) Contact Lens professional fitting fees.

(b) Elective Contact Lenses (elective contact lenses are contacts that are chosen for comfort or appearance).

(c) Non-Elective Contact Lenses are only provided for the following medical conditions.

- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when the patient's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

(d) Medically Necessary contact lenses are available in lieu of ophthalmic lenses and may be subject to Copayments, Coinsurance and limitations. The Provider determines a patient's qualifying criteria at examination and evaluation, and will obtain any necessary Precertification from us for these services.

(5) Low Vision Benefits

(a) Comprehensive Low Vision Exam.

(b) Optical/Non-optical aids.

(c) Supplemental testing.

(6) Non-Covered Services include services incurred for, or in connection with, any of the items below.

- Non-elective contact lenses for any Covered Person who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- For safety glasses and accompanying frames.
- For Inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Covered Person has reached the normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Contract.

- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Vision services for Covered Persons over the age of nineteen (19) unless specifically stated in this Contract.

ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS

A. **Non-Covered Services**. This Article 5 sets forth services that are excluded from coverage under this Contract and therefore are Non-Covered Services. Non-Covered Services are not covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

B. **Exclusions**. The following are Non-Covered Services:

(1) Services that we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.

(2) Services received from an individual or entity that is not a Provider.

(3) Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.

(4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

(5) Services provided as benefits by any governmental unit, unless otherwise required by law or regulation.

(6) Services for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

(7) Services for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

(8) Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

(9) Court ordered testing or care unless Medically Necessary.

(10) Services for which you have no legal obligation to pay in the absence of this or like coverage.

(11) Charges for consulting with Covered Persons by telephone, facsimile, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Covered Person except as otherwise described in this Contract.

(12) Surcharges for furnishing and/or receiving medical records and reports.

(13) Charges for doing research with Providers not directly responsible for your care.

(14) Charges that are not documented in Provider records.

(15) Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.

(16) Administrative, or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

(18) Services prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

(19) Completion of claim forms or charges for medical records or reports unless otherwise required by law.

(20) Missed or canceled appointments.

(21) Mileage, lodging and meals costs, and other travel related expenses, except as authorized by us or specifically stated as a Covered Service in this Contract.

(22) Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.

(23) Services incurred prior to the Effective Date.

(24) Services incurred after the termination date of this coverage except as specified elsewhere in this Contract.

(25) For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Complications directly related to Cosmetic Services treatment or surgery, as determined by us, are not covered. This exclusion applies even if the original Cosmetic Services treatment or surgery was performed while the Covered Person was covered by another carrier/self-funded plan prior to coverage under this Contract. “Directly related” means that the treatment or surgery occurred as a direct result of the Cosmetic Services treatment or surgery and would not have taken place in the absence of the

Cosmetic Services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

(26) Maintenance Therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance Therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

(27) Custodial Care, convalescent care or rest cures.

(28) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

(29) Services provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

(30) Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

(31) Services or care provided or billed by a school, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(32) Wilderness camps.

(33) For routine foot care (including the cutting or removal of corns and calluses), Nail trimming, cutting or debriding, Hygienic and preventive maintenance foot care, including but not limited to 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.

(34) Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

(35) Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to the following.

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

(36) 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.

(37) Dental implants.

(38) Dental braces.

(39) Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following.

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer or cleft palate.

(40) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

(41) Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

(42) Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by us, are not covered. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(43) Marital counseling.

(44) Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

(45) Vision orthotic training.

(46) Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.

(47) Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

(48) Services to reverse voluntarily induced sterility.

(49) Diagnostic testing or treatment related to infertility.

(50) Personal hygiene, environmental control, or convenience items including but not limited to the following.

- Air conditioners, humidifiers, air purifiers.
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals.
- Charges for non-medical self-care except as otherwise stated.
- Purchase or rental of supplies for common household use, such as water purifiers.
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds.
- Infant helmets to treat positional plagiocephaly.
- Safety helmets for Covered Persons with neuromuscular diseases.
- Sports helmets.

(51) Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

(52) Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by us, or as otherwise described in this Contract.

(53) Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.

(54) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

(55) For self-help training and other forms of non-medical self-care, except as otherwise provided in this Contract.

(56) Examinations relating to research screenings.

(57) Stand-by charges of a Provider.

(58) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

(59) Services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

(60) Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Contract.

(61) Manipulation Therapy services rendered in the home as part of Home Care Services.

(62) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. This Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

(63) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

(64) Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

(65) Any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(66) Surgical treatment of gynecomastia.

(67) Treatment of hyperhidrosis (excessive sweating).

(68) Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by us through Precertification.

(69) Complications directly related to a service or treatment that is a Non-Covered Service under this Contract because it was determined by us to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

(70) Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

(71) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

(72) Treatment of telangiectatic dermal veins (spider veins) by any method.

(73) Reconstructive services except as specifically stated in this Contract or as required by law.

(74) Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

(75) For non-preventive medical nutritional therapy.

(76) Abortions that are not Therapeutic Abortions.

C. Experimental/Investigative Health Care Services Exclusion. We do not provide coverage for any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be Experimental/ Investigative.

(1) 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.

(a) 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 granted.

(b) Has been determined by the FDA to be contraindicated for the specific use.

(c) Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

(e) 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.

(2) Any Health Care Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by us. In determining whether a Health Care Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

(a) The scientific evidence is conclusory concerning the effect of the Health Care Service on health outcomes.

(b) The evidence demonstrates the Health Care Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects.

(c) The evidence demonstrates the Health Care Service has been shown to be as beneficial for the total population for whom the Health Care Service might be proposed as any established alternatives.

(d) The evidence demonstrates the Health Care Service has been shown to improve the net health outcomes of the total population for whom the Health Care Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(3) Off-Label Drug Treatment. Coverage for a drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

(a) The drug is recognized for treatment of the indication in at least one standard reference compendium.

(b) The drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have

been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the drug's use to be contraindicated or the drug has not been approved by the FDA for any indication.

(4) The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

(a) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.

(b) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.

(c) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Documents of an IRB or other similar body performing substantially the same function.

(e) Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(f) Medical records.

(g) The opinions of consulting Providers and other experts in the field.

ARTICLE 6. OBTAINING COVERED SERVICES

A. Participating Providers.

(1) Unless otherwise specifically provided in this Contract, in order to receive Benefits under this Contract, a Covered Person must receive Covered Services from a Participating Provider.

(2) The Covered Person is responsible for verifying that a Provider is a Participating Provider. A list of Participating Providers is available online at [insert website] or by calling us at [toll free number].

B. Non-Participating Providers. Health Care Services received from Non-Participating Providers are Non-Covered Services except for the following circumstances.

(1) Emergency Health Care Services.

(a) If we determine that the Health Care Services were not an Emergency, the Health Care Services are Non-Covered Services and you will be responsible for costs associated with the Health Care Services.

(b) Subsequent follow up care by a Non-Participating Provider after the condition is no longer an Emergency is a Non-Covered Service unless specifically authorized by us.

(c) If a Covered Person is hospitalized in a Non-Participating Hospital due to an Emergency, you or the Provider must notify us within 48 hours of the admission. A continued stay after the condition is stabilized and is no longer an Emergency requires our written authorization. We may elect to transfer the Covered Person to a Participating Hospital once it is medically appropriate to do so.

(2) Non-emergency Medically Necessary Health Care Services that cannot be provided by a Participating Provider and for which the Covered Person has obtained a Referral from his/her Primary Care Physician.

(3) Maternity services for a Covered Person who was in her second or third trimester of pregnancy as of her Effective Date as provided in Article 3 Section K.

(4) When our agreement with a Participating Provider terminates, upon your written request, you may continue to receive Covered Services from the Provider for the following time periods.

(a) Up to sixty (60) days.

(b) In the case of Covered Person who is pregnant and in the third trimester of pregnancy, you may continue to receive Covered Services through the term of the pregnancy.

(c) For a Covered Person who is hospitalized until the Covered Person is discharged from Inpatient status.

C. Primary Care Physician.

(1) You must designate a Primary Care Physician for each Covered Person. If you do not select a Primary Care Physician we will assign one.

(2) The Covered Person's Primary Care Physician will be responsible for coordinating Covered Services and making referrals to other Participating Providers. A Covered Person does not need a referral from his/her Primary Care Physician for obstetrical or gynecological treatment from a Participating Provider. A Covered Person may seek care directly from an obstetrician or gynecologist that is a Participating Provider. For all other Providers, the Covered Person must obtain a referral from his/her Primary Care Physician to obtain benefits for Covered Services under this Contract.

(3) You may change the selection of a Primary care Physician no more frequently than once each month. A Covered Person may change his/her Primary Care Physician by submitting a written request, online at [insert website address], or by contacting us at the number shown on your Identification Card. A change in Primary Care Physician selection will be effective no later than thirty (30) days from the date we receive a request.

ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES.

This Article 7 sets forth the procedures for requesting approvals for Covered Services from us as well as general Grievance procedures. In processing claims, we review requests for Precertification, Predetermination, and Post Service Clinical Claims Review to determine whether provided or proposed to be provided Health Care Services are Covered Services. Health Care Services must be Medically Necessary for Health Care Services to be considered Covered Services.

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A. Covered Service Review Requests

(1) Types of Covered Service Review Requests.

(a) Precertification – 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.

(b) Predetermination – An optional, voluntary prior or concurrent request for a benefit coverage determination for a Health Care Service. We will review your Contract to determine if there is an Exclusion for the service or treatment requested. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service or treatment meets our definition of Medical Necessity, or if it is Experimental/Investigative as that term is defined in this Contract.

(c) Post Service Clinical Claims Review – A retrospective review (Post-Service) for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Precertification and did not undergo a Predetermination review. Post Service Clinical Claims Reviews are done for Health Care Services for which we have a related clinical coverage guideline and are typically initiated by us.

(2) Most Participating Providers know which Health Care Services require Precertification and will get Precertification or ask for Predetermination from us as needed. Your Primary Care Physician and all other Participating Providers have received information from us on the procedures for requesting approvals for Covered Services and are responsible for meeting the requirements under such procedures. Generally, the Participating Provider ordering the service, treatment or admission will contact us to ask for Precertification or Predetermination reviews ("Requesting Provider"). We will work directly with your Requesting Provider regarding such review requests; however, your Designated Representative may act on your behalf throughout the review process.

(3) We will utilize our clinical coverage guidelines, including internally developed guidelines, procedures, and preventative care clinical coverage guidelines, to help us determine whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions Identified

as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

(4) You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact us at [toll free number].

B. Review Request Categories.

(1) Urgent Care – A request for Precertification or Predetermination that in the view of your attending Provider, or any physician with knowledge of your medical condition, could seriously jeopardize your life or health or your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Urgent Care Claim.

(2) Pre-Service – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

(3) Concurrent Care – A request for Precertification or Predetermination that is conducted during an ongoing course of treatment or admission. If we have approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by us of such course of treatment before the end of such period of time or number of treatments shall constitute a benefit determination adverse to you. We will notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination before the benefit is reduced or terminated.

(4) Post-Service – A request for approval that is made after the service, treatment or admission has occurred. Post-Service review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

C. Benefit Decision and Notice Requirements.

(1) We will resolve benefit review requests according to the timeframes listed in the table below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws.

Request Categories	**Timeframe Requirement for Benefit Decisions and Notification**
Pre-Service Claim	15 calendar days from receipt of request
Pre-Service Urgent Care Claim	72 hours from receipt of request
Concurrent Care Claim	15 calendar days from receipt of

	request
Concurrent Urgent Care Claim	24 hours from receipt of request
Post-Service Claim	20 business days from receipt of request

D. Timeframe Extensions for Benefit Decisions and Notifications.

(1) Post-Service and Pre-Service Claims. If we are unable to complete our review due to circumstances beyond our control, we will notify you, your Designated Representative, and the Requesting Provider in writing within:

(a) Fourteen (14) days after our receipt of a Pre-Service claim review request, and

(b) Nineteen (19) days after our receipt of a Post-Service claim review request.

The written notice will include the reason for the delay, a list of any applicable additional information that we need from you in order to complete our review and a revised timeframe for the resolution. If the reason for the delay is because your review request lacked sufficient information to complete our review of your request, you, your Designated Representative and Requesting Provider will have forty-five (45) days from receiving our notice of delay to provide the necessary information. We will notify you, your Designated Representative and the Requesting Provider of our decision within not more than ten (10) days after notifying you, your Designated Representative and Requesting Provider of the reason for our delay or of our receipt of the necessary information or of the end of the period afforded to you to supply the necessary information, as applicable. If we do not get the specific information we need or if the information is not complete by the timeframe provided to you, we will make a decision based upon the information we have.

(2) Urgent Care Claims. If you fail to provide us with sufficient information to review your Urgent Care Claim review request, we will notify you as soon as possible, but not later than twenty-four (24) hours after our receipt of the claim, of the specific information necessary to complete our review. You will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. We will notify you, your Designated Representative and Requesting Provider of our decision as soon as possible, but in no case later than forty-eight (48) hours of the earlier of the following:

(a) our receipt of the necessary information, or

(b) the end of the period afforded to you to supply the necessary information.

If we do not get the specific information we need or if the information is not complete by the timeframe provided to you, we will make a decision based upon the information we have.

E. Denial of Experimental Treatment.

If we deny coverage for a treatment, procedure, drug or device on the grounds that the treatment, procedure, drug or device is experimental, we will provide you with a written explanation that includes the following information:

(a) The basis for the denial.

(b) Your right to Appeal our decision.

(c) Our telephone number that you may contact for assistance in initiating an Appeal of our decision.

(2) If your health situation is life threatening or is an emergency, you are entitled to a review of our decision to deny coverage on the grounds that the treatment, procedure, drug or device is experimental that takes not more than seventy-two (72) hours.

F. What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(1) Availability, delivery, appropriateness, or quality of health care services.

(2) Handling or payment of claims for health care services.

(3) Matters pertaining to the contractual relationship between you and us.

G. Who May File.

(1) You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

(2) If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

H. How a Grievance May Be Filed.

(1) You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, including fax]

(2) A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

I. No Retaliation. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 7.

J. Grievance Procedure.

(1) Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

(2) Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

(3) Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

(4) Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

(5) Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

K. Appeals Procedure.

(1) Right to an Appeal.

(a) If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

(b) You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

(c) The Appeal may be expressed orally or in writing by contacting us at the address and phone number provided below.

[Address]

(d) We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

(2) Appeal Panel.

(a) We will appoint a panel of qualified individuals to resolve your Appeal (the "Appeal Panel"). The Appeal Panel will resolve your Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

(b) The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date and place during normal business hours for the Appeal Panel to meet to discuss your Appeal. You will be given seventy-two (72) hours advance notice of the date and time of the meeting.

(c) You or Your Designated Representative may:

(a) appear in person before the Appeal Panel; or

(b) communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

(d) You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

(e) To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

(f) The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

(g) If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:

(a) Has knowledge in the medical condition and Health Care Service;

(b) Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and

(c) Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with you or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.

(3) Appeal Decision and Notice of Decision.

(a) The Appeal Panel's decision regarding your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

(b) The Appeal Panel will resolve Appeals according to the timeframes listed in the table below.

Appeal Categories	**Timeframe Requirement for Appeal Decisions and Notification**
Appeal of a Pre-Service Claim Decision	30 calendar days from our receipt of the Appeal
Appeal of a Pre-Service Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Concurrent Care Claim Decision	15 calendar days from our receipt of the Appeal
Appeal of a Concurrent Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Post-Service Claim Decision	45 calendar days from our receipt of the Appeal

(c) We shall notify you or your Designated Representative of our decision in writing regarding your Appeal within five (5) business days after we complete our investigation.

(4) Expedited Review of Internal Appeals.

(a) An Expedited Review of an internal Appeal may be initiated orally, in writing or by other reasonable means available to you, your Designated Representative or your Provider.

(b) Expedited Review is available only if your attending Provider believes that, based upon your medical condition, our standard internal Appeal procedure could seriously jeopardize your life or health or your ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed.

(c) Appeals of Urgent Care Claim decisions are referred directly to our Expedited Review procedure for investigation and resolution.

(d) We will complete our Expedited Review of your Appeal as soon as possible given the medical exigencies but no later than within 72 hours after our receipt of your request for Appeal.

Deleted: <#>Benefit Decision Appeals¶
<#>Your Right to Appeal. If you or your Requesting Provider disagrees with our decision regarding your benefit review request you or your Designated Representative may initiate an Appeal by contacting us either in writing and/or by phone at the address and phone number provided below.¶
[Address]¶
Your Appeal must be initiated within 180 days of receiving our decision regarding your benefit review request. We will acknowledge your Appeal within 3 business days of our receipt of your Appeal Request. ¶
<#>Appeal Panel. We will appoint a panel of qualified individuals to resolve your Appeal (the "Appeal Panel"). We will ensure that no individual is appointed to the Appeal Panel who was involved in the matter giving rise to the compliant or in the initial investigation of the complaint. ¶
<#>If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:¶
<#>Has knowledge in the medical condition and Health Care Service;¶
<#>Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and¶
<#>Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with you or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.¶
<#>The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date and place during normal business hours for the Appeal Panel to meet to discuss your Appeal. You will be given seventy-two (72) hours advance notice of the date and time of the meeting. You or your Designated Representative may appear in person at the Appeal Panel meeting or communicate with the Appeal Panel through appropriate other means if you or your Designated Representative are unable to appear in person. ¶
Timeframe for Resolution of Appeals

(e) We will communicate our decision regarding your Appeal by telephone to you, your Designated Representative, and your attending Provider. We will also provide written notice of our decision to you, your Designated Representative and your attending Provider.

(f) An Expedited Review of Concurrent Urgent Care Claims and Pre-Service Urgent Care Claims may occur at the same time as an External Review (as described below).

L. External Review

(1) You or your Designated Representative may seek External Review if our decision regarding your Appeal upheld a decision that was adverse to you regarding any of the following.

(a) A Medically Necessary service.

(b) A utilization review decision.

(c) A determination that a proposed service is Experimental/Investigational.

(d) A decision to rescind your Contract.

If your Appeal did not involve one of the above adverse decisions, you are not entitled to an External Review.

(2) If you have the right to an External Review under Medicare (42 U.S.C. 1395, et seq.) you may not request an External Review of our Appeals decision under the procedures outlined in this Contract.

(3) If your situation qualifies, you or your Designated Representative must file a written request for an External Review with us within 120 days after you receive notice of our internal response to the Appeal.

(4) Independent Review Organization (IRO).

(a) If an External Review is requested, we will forward all information related to your External Review to an IRO selected from the list of IROs that are certified by the Indiana Department of Insurance.

(b) The IRO will make a determination to uphold or reverse our Appeal decision within seventy-two (72) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within fifteen (15) business days if the condition does not involve an Urgent Care Claim.

(c) The IRO will notify you and your Designated Representative of its decision within twenty-four (24) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within seventy-two (72) hours if the review does not involve an Urgent Care Claim.

(d) If the IRO decision reverses our Appeals decision, we will notify you, your Designated Representative or Provider in writing of the steps we will take to comply with the IRO's decision.

M. Important Contact Information and Notice to Covered Persons

(1) Questions regarding your coverage should be directed to: Indiana University Health Plans; [toll free number]

Deleted: [

Deleted:]

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

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

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

(3) Complaints can also be filed electronically at www.in.gov/idoi.The review procedures described in this Article 7 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

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ARTICLE 8. PAYMENT FOR COVERED SERVICES

A. How to Obtain Benefits.

(1) Whenever you receive Health Care Services, you must provide the Provider with a copy of your Identification Card.

(2) When you receive Covered Services from a Participating Provider you are not required to file a claim. Since no claim filing is required, you are not required to follow the procedures outlined in Section C of this Article 8.

B. Who Receives Payment Under This Contract.

(1) We pay Benefits for your Covered Services directly to a Participating Provider.

(2) If you receive Covered Services from a Non-Participating Provider as provided in Article 6 Section B, we will pay Benefits to the Non-Participating Provider, unless you agreed to make payment to the Non-Participating Provider and are entitled to reimbursement for such payment.

C. Payment for Covered Services received from Non-Participating Providers.

(1) Time to File Claims. For Covered Services received from a Non-Participating Provider, written notice of a claim must be given to us, by you or the Non-Participating Provider, within thirty (30) days of the date the Covered Services began. Failure to furnish the claim within thirty (30) days will not invalidate or reduce any claim if submission within thirty (30) days was not reasonably possible, so long as the claim is submitted within a reasonable time.

(2) Claim Forms. We shall provide forms to you for filing Proof of Loss within fifteen (15) days of notice of any claim. If you do not receive the forms within fifteen (15) days, written notice of services rendered may be submitted to us without the claim form. Claim forms are available on our website at [website address].

(3) Proof of Loss. Proof of loss under this Contract must be furnished to us within ninety (90) days after the loss. Failure to furnish the claim within ninety (90) days will not invalidate or reduce any claim if submission within ninety (90) days after the loss was not reasonably possible, so long as the claim is submitted within one (1) year after the time required under this Contract unless you were legally incapacitated.

(4) Address. All correspondence regarding claims should be sent to us at:

Indiana University Health Plans
[Address]
[City/state/zip]
[Fax]

Deleted: [
Deleted:]

(5) Amount of Payment. Payment for Health Care Services received from a Non-Participating Provider will be the lesser of the following amounts.

(a) The usual, customary and reasonable charge for the Health Care Service;

(b) An amount agreed upon by us and the Non-Participating Provider.

D. Clean Claims.

(1) A clean claim is a claim submitted by a Provider for payment that has no defect. We shall pay or deny each clean claim as follows.

(a) If the claim is filed electronically, within thirty (30) days after the date we receive the claim.

(b) If the claim is filed on paper, within forty-five (45) days after the date we receive the claim.

(2) If we fail to pay or deny a clean claim in the time frames set forth above and subsequently pay the claim, we will pay the Provider that submitted the claim allowable interest in accordance with Indiana Code § 27-8-5.7-6.

ARTICLE 9. COORDINATION OF BENEFITS

This Article applies only if you also have other health benefits coverage with another Plan. The Definitions contained in this Article apply throughout this Article 9 but do not apply to the rest of the Contract.

A. **When you have other health benefits**. In the event that you are covered by two health insurance contracts, plans or policies ("Plans") providing similar benefits and you receive a Health Care Service that would be covered by both Plans, we will coordinate benefit payments with any payment made under the other Plan. One company will pay its full benefit as the Primary Plan. The other company will pay Secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments.

B. **Definitions**.

(1) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the Plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(2) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

(3) "Closed Panel Plan" means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in the case of emergency or referral by a panel Covered Person.

(4) "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(5) "Plan" means any of the following that provides benefits or services for medical treatment:

(a) Any group or blanket insurance contract, plan or contract, except that blanket school accident coverage or such coverage offered to

substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or contract.

(b) Any self-insured or noninsured Plan or any other Plan arranged through an employer, trustee, union, employer organization or employee benefit organization.

(c) Any coverage under governmental programs or any coverage required to be provided by any statute. However, Medicaid and any Plan whose benefits are, by law, excess to those of any private insurance plan or other nongovernmental plan shall not be considered health insurance policies.

(d) Group or nongroup coverage through Closed Panel Plans or group type contracts.

(e) Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional "fault" type contracts.

(6) "Primary" or "Primary Plan" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If the Plan is Primary to another Plan, the Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(7) "Secondary" or "Secondary Plan" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If the Plan is Secondary to another Plan, the Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

C. **Rules To Determine Payment**. When two or more Plans pay benefits, the rules for determining the order of payments are as follows:

(1) The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

(2) If the other Plan does not have a provision similar to this one, then it will be primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(3) A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. **Order of Determination of Benefits Rules**: The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent is Primary, for example as an employee, subscriber or retiree is

primary and the Plan that covers the person as a Dependent is Secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent; then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, subscriber or retiree is Secondary and the other Plan is Primary.

(2) Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods commencing after the Plan is given notice of the court decree.

(d) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(a) The Plan of the Custodial Parent.

(b) The Plan of the spouse of the Custodial Parent.

(c) The Plan of the non-Custodial Parent.

(d) The Plan of the spouse of the non-Custodial Parent.

(3) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is Primary. The same would hold true is a person is a Dependent of a person covered as a retiree or an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined Section (C)(1) of this Article 9.

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, subscriber or retiree (or as that person's Dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, subscriber or retiree longer is Primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid if it had been Primary.

E. Payment of the Benefit When This Plan is Secondary.

(1) When this Plan is Secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other Plan and this Plan do not exceed your expenses for an item of service. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by the Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

(a) Determine its obligation to pay or provide benefits under its Plan;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

(2) If there is a benefit reserve, the Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

(3) If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, Coordination of Benefits shall not apply between that Plan and other Closed Panel Plans.

F. Payments to others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid.

G. Our Right to Recover Overpayment. In some cases, we may have made payment even though you had coverage under another Plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the

payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other Plan. You agree to sign any document that we deem necessary to help us recover any overpayment.

ARTICLE 10. TERMINATION OF COVERAGE

A. [**Guaranteed Renewable.** As long as you continue to be a Qualified Individual and this Contract continues to be a Qualified Health Plan, you may renew this Contract at your option without regard to the health status of you or any Covered Person.]

[Guaranteed Renewable. Coverage under this Contract is guaranteed renewable at the discretion of the Subscriber, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, as described in this Article 10. You may renew this Contract at your option without regard to the health status of you or any Covered Person. You may renew this Contract by payment of the renewal premium by the end of the Grace Period of the premium due date, provided the following requirements are satisfied:

(1) Eligibility criteria outlined in Article 2 continues to be met.

(2) There are no fraudulent or intentional misrepresentations on the application or under the terms of this Contract.

(3) Coverage has not been terminated by us under the terms of this Contract.]

B. **Termination.** We may terminate this Contract or coverage of a Covered Person for the following reasons.

(1) You are no longer eligible for coverage [through the Indiana Marketplace].

(2) A Covered Person is no longer eligible under [the rules of the Indiana Marketplace or] the terms of this Contract.

(3) You do not pay premium and the applicable Grace Period has been exhausted.

(4) We receive a request from you to terminate the Contract.

(5) You commit an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact.

(6) You change coverage to another [Qualified Health Plan] [health plan] during the [Indiana Marketplace] Open Enrollment Period or a Special Enrollment Period.

(7) [The Contract is no longer a Qualified Health Plan or we are decertified by the Indiana Marketplace.]

(8) You no longer reside in our Service Area.

(9) We discontinue a particular product provided that we provide you with written notice at least ninety (90) days before the date the product will be discontinued, we offer you the option to purchase any other individual contract we currently offer, and we act uniformly without regard to any health status-related factor.

(10) We discontinue all contracts in the individual market in Indiana provided that we provide you and the Indiana Department of Insurance with written notice at least 180 days before the date of the discontinuance, we discontinue and do not renew

all contracts in the individual market in the State of Indiana, and we act uniformly without regard to any health status-related factor.

(11) We may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with the laws of the State of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

C. Effective Date of Termination. [Termination of this Contract automatically terminates all coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.]

(1) If you terminate this Contract or coverage for a Covered Person, the last day of coverage [will be on the last day of the billing period for which premium has been paid. A request for termination must be received by us in writing] [is:

(a) The termination date specified by you, if reasonable notice is provided;

(b) If you do not provide reasonable notice, fourteen (14) days after the termination is requested, or

(c) If you do not provide reasonable notice and request a termination date in less than fourteen (14) days, on a date determined by us if we are able to implement termination in fewer than fourteen (14) days.]

(2) [If newly eligible for Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.]

(3) [If you are no longer eligible for coverage through the Indiana Marketplace, the last day of coverage is the last day of the month following the date notice is sent to us by the Indiana Marketplace, unless you request an earlier termination effective date.] [If you move outside of the Service Area, the last day of coverage for you and all of your Dependents will be at the end of the billing period that contains the date you no longer resided in the Service Area.]

(4) [If a Covered Person is no longer eligible for coverage under the rules of the Indiana Marketplace or the terms of this Contact, the last day of coverage is the last day of the month following the date the Covered Person loses eligibility.] [If a Dependent no longer meets the definition of Dependent, the last day of coverage for the Dependent will be on the last day of the billing period in which we received notice of the Dependents loss of eligibility.]

(5) In the case of a termination for non-payment of premium and the applicable Grace Period has been exhausted, the last day of coverage [for all Covered Persons] will [be either the last day of the first month of the 3-month Grace Period or] the last day for which premium was paid.

(6) [In the case of a termination due to a change to another Qualified Health Plan, the last day of coverage is the day before the effective date of coverage in his or her new Qualified Health Plan.]

(7) The day following a Covered Person's death. When a Subscriber dies, the surviving spouse, if covered under the Contract, may receive an individual contract. The surviving spouse should contact [the Indiana Marketplace] [us] to identify the process for enrollment.

D. Notice of Termination.

(1) We shall provide you with written notice of our intent to terminate or not renew this Contract at least sixty (60) days prior to the effective date of the termination. This notice will identify the date upon which your coverage will terminate.

(2) Our notice to the Subscriber shall be deemed as notice to all Covered Persons and is sufficient if mailed to the Subscriber's address as it appears in our records.

(3) Termination of this Contract shall not prejudice any claim for Covered Services rendered before the effective date of the termination.

E. Continuation of Coverage.

(1) If we terminate this Contract, except for a termination due to our receivership, and a Covered Person is hospitalized for a medical or surgical condition on the effective date of the termination, coverage will continue for Inpatient Covered Services. Benefits shall end on the earliest of the following dates.

(a) The date the Covered Person is discharged from the Hospital.

(b) The date the Covered Person is covered under other health coverage if that coverage covers the Inpatient Hospital services.

(c) Sixty (60) days after the date this Contract ends.

(d) The last day the required premium has been paid if the Grace Period expires and the Subscriber has not made the required payment.

(e) The date the you terminate coverage.

(2) If this Contract terminates due to our receivership, coverage will continue for the following time period:

(a) The duration of the contract period for which premiums have been paid.

(b) If a Covered Person is hospitalized on the date of our receivership for the longer of the following time periods.

(A) The period ending when the Covered Person is discharged from the Inpatient hospitalization.

(B) The duration of the contract period for which premiums have been paid.

F. **Rescission.** If within two (2) years after the Effective Date of this Contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or a Covered Person did not disclose on your application, we may rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding your newly born children within 31 days of birth), we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or a Covered Person did not disclose on the application, we may rescind coverage for the additional Dependent as of his or her original Effective Date. Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by a Covered Person may result in termination or rescission of coverage. You are responsible to pay us for the cost of previously received services based on the Allowed Amount for such services, less any Copayments/Coinsurance paid or Premium paid for such services.

This Contract may also be terminated if you knowingly participate in or permit fraud of deception by any Provider, vendor or any other person associated with this Contract. Termination for any act, practice or omission that constituted fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give you at least thirty (30) days written notice prior to the rescission of this Contract.

G. **Reinstatement.** If your Contract was terminated for non-payment of premium, you may request reinstatement of the Contract from [the Indiana Marketplace] [us] within 30 days of the effective date of the termination. You must remit all premium that was due for the coverage upon reinstatement. Upon [notice from the Indiana Marketplace and] receipt of the outstanding premium, we will reinstate coverage as of the effective date of the termination.

H. [**Certification of Prior Creditable Coverage If Required by Law.** If your coverage is terminated, you and your Dependents will receive certification from us showing that you were covered under this Contract. You may need this certification document in order to purchase, for yourself and/or your family, other health coverage. Certifications may be requested within twenty-four (24) months of losing coverage.

You may also request certification be provided to you at any other time, even if you have not lost your coverage under this Contract. If you have any other questions regarding certification of creditable coverage, contact the Customer Service telephone number on the back of your Identification Card.]

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<#>GRIEVANCE PROCEDURES ¶
The Grievance procedures provided in this Article 11 are established and maintained by us for the filing, investigating, and resolving of Grievances and Appeals that are ***unrelated to benefit decisions*** that are adverse to you. ***For procedures applicable to benefit decisions please refer to Article 7 of this Contract.***¶
What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.¶
<#>Availability, delivery, appropriateness, or quality of health care services.¶
<#>Handling or payment of claims for health care services.¶
<#>Matters pertaining to the contractual relationship between you and us.¶
<#>Who May File. ¶
<#>You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure. ¶
<#>If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.¶
<#>**How a Grievance May Be Filed.** ¶
<#>You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.¶
[Address, including fax] ¶
<#>A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing. ¶
No Retaliation. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 10 or Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 10 or Article 7.¶
<#>**Grievance Procedure**. ¶
<#>Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken. ¶
<#>Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.¶
<#>Decision. Our decision regarding your Grievance must be made as soon as pos... [1]

ARTICLE 11. GENERAL PROVISIONS

A. **Entire Contract**. This Contract, the Schedule of Benefits, and any application, rider or amendment(s) make up the entire agreement between you and us as of the Effective Date and supersede all other agreements. All statements made by you shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce coverage under this Contract or be used in defense of a legal action unless it is contained in the application.

B. **No Assignment**. The benefits provided under this Contract are for your and your enrolled Dependents' personal benefit. You may not assign any of your rights to coverage. Any attempt by you to assign this Contract to any third party is void. Provided, however, that subject to our right to disapprove, you may assign your right to reimbursement for Covered Services to the Provider who provided such Covered Services.

C. **Notice**. Any notice that we give to you under this Contract will be mailed to your address as it appears on our records. Our notice to the Subscriber is deemed notice to all enrolled Dependents. Notice is deemed delivered three (3) calendar days after its deposit in the United State Mail with first class postage prepaid unless otherwise stated in this Contract. If you have to give us any notice, it should be mailed to:

Indiana University Health Plans, Inc.
950 North Meridian Street, Suite 200
Indianapolis, Indiana 46204

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D. **Relationship Between Parties**. The relationships between us and Participating Providers are *solely* contractual relationships between a payor and independent contractors. Non-Participating Providers have no contractual relationship with us, nor are they our independent contractors. Providers are not our agents or employees. We and our employees are not employees or agents of Providers. The relationship between a Provider and any Covered Person is that of Provider and patient. The Provider is *solely* responsible for the services provided to any Covered Person.

E. **Disagreement with Recommended Treatment.** Each Covered Person enrolls in this Contract with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate Health Care Services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice. If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, the Provider and we, as applicable, may determine that neither this Contract nor the Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of this Contract for the condition under treatment or any complications thereof.

F. **Your Medical Records**. As a condition precedent to the approval of claims hereunder, each Covered Person authorizes and directs any Provider that furnishes benefits hereunder to make available to us information relating to all Health Care Services, copies thereof and other records as needed by us for purposes of administering this Contract. In every case we will hold such information and records as confidential in accordance with state and federal confidentiality requirements.

G. **Second Opinion Policy**. A second opinion may be required at our discretion prior to the scheduling of certain Covered Services. We will advise you if a proposed Covered Service is subject to the second opinion policy. If so, you must consult with a second Participating Provider prior to the scheduling of the service. You must (a) contact us to obtain a list of Participating Providers who are authorized to render a second opinion, and (b) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider. You must obtain the second opinion within thirty-one (31) days of the first opinion or as soon thereafter as is reasonably possible. Second opinions we have arranged as described above are provided at no cost to you. A second opinion may also be obtained at the request of a Covered Person, subject to separate benefit restrictions and/or Copayments or Coinsurance described in this Contract.

H. **Who May Change This Contract**. This Contract may not be modified, amended or changed, except in writing, and signed by one of our officers. No employee, agent or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage or the conditions of eligibility, enrollment or participation unless in writing and signed by one of our officers. We are not bound by any verbal statements. We will provide you with written notice of any material modification to this Contract not later than sixty (60) days prior to the date on which such material modification will become effective.

I. **Renewal Date**. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date for the term set forth in the Contract unless otherwise terminated by us as permitted by the Contract or by you upon thirty (30) days' prior written notice.

J. **Identification Cards**. Identification Cards are issued by us for identification only. Possession of any Identification Card confers no right to services or benefits under this Contract. To be entitled to such services or benefits the Covered Person's premiums must be paid in full at the time the Health Care Services are sought to be received. Coverage under this Contract may be terminated by us if the Covered Person allows another person to wrongfully use the Identification Cards.

K. **Right to Develop Guidelines and Administrative Rules**. We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Contract. An example of the use of the standards is to determine whether care was Medically Necessary. These standards will not be contrary to the descriptions in this Contract. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Contract.

L. **Non-Discrimination**. In compliance with state and federal law, we shall not discriminate on the basis of age; gender; color; race; disability; marital status; sexual preference; religious affiliation; or public assistance status. We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care. We shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew Coverage, (b) cancel coverage, (c) limit Benefits, or (d) charge a different premium. We shall not discriminate against victims of abuse in compliance with Indiana Code Sec. 27-8-24.3-1.

M. **Incontestability**. The validity of the Contract may not be contested after two (2) years, except for nonpayment of premiums or if the disputed statement is in a written instrument signed by the Subscriber. The ineligibility of the Subscriber or a Dependent under the Contract may be disputed at any time.

N. **Limitation of Action**. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Contract and within three (3) years from the date the Health Care Services were received.

Deleted: The Subscriber's damages shall be limited to recovery of actual Benefits due under the terms of this Contract. The Covered Person waives any right to recover any additional amounts or damages including, but not limited to, punitive and/or exemplary damages.

O. **Examination of Covered Persons**. We may reasonably require that you be examined if a question or dispute about the provision of or payment for Covered Services arises. The exam will be performed by a Participating Provider acceptable to us. We will pay for the exam.

P. **Right of Recovery.** If we pay for Health Care Services that, according to the terms of the Contract, should not have been paid, we reserve the right to recover such amounts from whom they have been paid (including the Covered Person or Provider) or any other appropriate party.

Q. **Contract is not a Medicare supplement policy**. Any Covered Services that are covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled. The benefits under this Contract for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be Primary. Where Medicare is Primary, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

R. **Contract is Not Worker's Compensation Insurance**. The coverage provided under this Contract does not replace, supplement or provide a substitute for benefits to which a Covered Person is entitled under worker's compensation, occupational disease, and similar laws. The Contract does not cover Health Care Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's

compensation, occupational disease and similar laws, even when the circumstances below are present.

(1) If the Covered Person's employer is not properly insured or self-insured under such laws.

(2) When a Covered Person refuses to use his or her employer's designated Provider.

(3) When a Covered Person has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

A Covered Person must contact his employer or its worker's compensation or occupational disease insurer for the provision or payment of such Health Care Services.

S. **General Conditions for Benefits**. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within our control we will pay benefits for Covered Services as provided in this Contract to the extent that facilities and personnel are then available, and we shall have no liability or obligation for delay or failure to provide Covered Services due to lack of available facilities or personnel.

T. **Typographical or Administrative Error**. Typographical or administrative errors shall not deprive a Covered Person of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

U. **Conformity with Statutes**. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on the Effective Date shall apply. Any Contract provision which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

V. **Governing Law.** This Contract will be subject to the laws of the state of Indiana.

W. **Severability.** In the event that any provision in the Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

[Schedule of Benefits]

Page 84: [1] Deleted	Hilderbrand, Jennifer B.	5/27/2014 3:53:00 PM

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GRIEVANCE PROCEDURES

The Grievance procedures provided in this Article 11 are established and maintained by us for the filing, investigating, and resolving of Grievances and Appeals that are ***unrelated to benefit decisions*** that are adverse to you. ***For procedures applicable to benefit decisions please refer to Article 7 of this Contract.***

What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

Availability, delivery, appropriateness, or quality of health care services.

Handling or payment of claims for health care services.

Matters pertaining to the contractual relationship between you and us.

Who May File.

You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

How a Grievance May Be Filed.

You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, including fax]

A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

No Retaliation. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 10 or Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 10 or Article 7.

Grievance Procedure.

Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

Appeals Procedure.

Right to an Appeal.

If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

The Appeal may be expressed orally or in writing.

We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

Appeal Panel.

Our Appeal Panel (the "Appeal Panel") will resolve the Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

You or Your Designated Representative may:

appear in person before the Appeal Panel; or

communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

Appeal Decision and Notice of Decision.

The Appeal Panel's decision regarding Your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

We will notify you in writing of the Appeal Panel's decision within five (5) business days after it is decided.

Notice to Covered Persons.

If you have questions regarding your rights under this Contract or if you need Assistance, please contact us at:

[Indiana University Health Plans]
[toll free number]

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

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

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

Complaints can be filed electronically at www.in.gov/Idoi.

The review procedures described in this Article 11 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

[Insert logo left/center/right]

CHILD-ONLY CONTRACT
[Issued through the Indiana Marketplace]
(herein called the "Contract")

[Product Name]

Issued by:

Indiana University Health Plans, Inc.
an Indiana domestic health maintenance organization
950 North Meridian Street
Indianapolis, Indiana 46204

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[This coverage is issued through the Indiana Marketplace to provide coverage for a Dependent.] This Contract sets forth in detail the rights and obligations of the Subscriber. It is important that you **read this Contract carefully.** This Contract provides coverage only for enrolled Dependents. This Contract includes limitations and exclusions. You should familiarize yourself with its terms and conditions before receiving Health Care Services. Capitalized terms have the meaning set forth in the Definitions sections.

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, you may return it to us or the agent who sold it to you within 10 days after your receipt. Your premium will be refunded and this Contract with be void from its start. Any Health Care Services received during this 10-day period are solely your responsibility.

Benefits under this Contract may vary depending on other medical expense insurance you may have.

If you have questions related to the health insurance coverage provided under this Contract, you may contact us at [toll free number] [or the Indiana Marketplace at www.healthcare.gov or [toll free number].]

[signature]
President

[**DISCLAIMER:** The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace.]

TABLE OF CONTENTS

PAGE

ARTICLE 1. DEFINITIONS 1
ARTICLE 2. ELIGIBILITY AND ENROLLMENT. 9
ARTICLE 3. YOUR FINANCIAL OBLIGATIONS 16
ARTICLE 4. COVERED SERVICES 19
ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS 54
ARTICLE 6. OBTAINING COVERED SERVICES 63
ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES 65
ARTICLE 8. PAYMENT FOR COVERED SERVICES 74
ARTICLE 9. COORDINATION OF BENEFITS 76
ARTICLE 10. TERMINATION OF COVERAGE 81
ARTICLE 11. GENERAL PROVISIONS 85

ARTICLE 1. DEFINITIONS

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, Dependent or Covered Person, either collectively or individually as appropriate to the reference.]

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[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber, or the Dependent or Covered Person, either collectively or individually as appropriate to the reference.]

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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.

Approved Clinical Trial – a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

(a) A trial that is approved or funded by one, or a combination, of the following.

(a) The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services.

(b) The United States Food and Drug Administration.

(c) The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(d) The United States Department of Veteran’s Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(e) The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).

(f) The Centers for Disease Control and Prevention.

(g) The Agency for Health Care Research and Quality.

(h) The Centers for Medicare and Medicaid Services (CMS).

(i) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks.

(j) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(k) A qualified non-governmental research entity in guidelines issued by the National Institutes of Health for center support grants.

(2) A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.

(3) A study or investigation done for drug trials which are exempt from the investigational new drug application.

For purposes of this definition, the term "life threatening condition" means any disease or condition from which death is likely unless the disease of condition is treated.

Behavioral Health – a physical or behavioral condition having an emotional or psychological origin or effect, including substance abuse. Behavioral Health Services include mental health services and substance abuse services.

Benefits – your right to payment for Covered Services under this Contract subject to the terms, conditions, limitations, and exclusions of this Contract.

Child or Children – a child of the Subscriber or Subscriber's spouse, including any of the following until the Child attains the age of 21.

- Natural child,
- Stepchild,
- Legally adopted child,
- Child placed for the purpose of adoption, or
- Child placed under legal guardianship or legal custody.

Child includes a child of any age who is incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 26 and the Subscriber principally supports the Child. Proof of the disability must be submitted to us within thirty-one (31) days of the child's 21st birthday. For two years we may require proof of the child's continuing disability and dependency at reasonable intervals. After two years, we may require proof of the child's disability and dependency no more than once per year.

Coinsurance – a percentage of the Allowed Amount that the Subscriber must pay for certain Covered Services. Coinsurance amounts are set forth in the Schedule of Benefits.

Contract – this individual contract issued by Indiana University Health Plans, Inc. which provides Benefits for Covered Services received by and enrolled Dependents. The term Contract includes the Schedule of Benefits, any application, amendments and riders.

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Copayment – a fixed amount the Subscriber pays to a Provider for a Covered Service. The amount of a Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

Cosmetic Services – Health Care Services primarily intended to preserve, change or improve a Covered Person's appearance or are furnished for psychiatric or psychological reasons.

Cost Sharing – the amount you are required to pay for Covered Services. Cost Sharing can be in the form of Copayments, Coinsurance or Deductibles.

Covered Person –any Dependent who meets all applicable eligibility requirements for coverage under this Contract, is enrolled as provided in this Contract, and for whom the required premium payment has been received by us.

Covered Services – Health Care Services provided to a Covered Person performed, prescribed, directed or authorized by a Provider and for which this 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 this Contract is in force.
- Not experimental/investigative.
- Authorized in advance by us if Precertification is required under this Contract.
- Not excluded or limited by this Contract.

Deductible – the amount the Subscriber must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The amount of the Deductible is set forth in the Schedule of Benefits.

Dependent – an individual who satisfies the eligibility requirements to enroll as a Dependent as set forth in Article 2.

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 [website] 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.

Durable Medical Equipment – Medical equipment that:

- can withstand repeated use and is not disposable,
- is used to serve a medical purpose,
- is generally not useful to a person in the absence of a Sickness or injury,
- is appropriate for use in the home, and
- is the most cost-effective type of medical apparatus appropriate for the condition.

Effective Date – the date when coverage under this Contract begins.

Emergency Medical Condition or Emergency – a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent 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 woman, the health of the

woman or her unborn child) in serious jeopardy.
- Serious impairment to a person's bodily functions.
- Serious dysfunction of a bodily organ or part of a person.

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, 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, 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 woman 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 woman or the unborn child.

FDA – the United States Food and Drug Administration.

Grace Period – the time period for payment of premium set forth in Article 3 Section B.

Health Care Services – medical or health care services, whether or not covered under this 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.

Indiana Marketplace – the health benefit exchange established by the Affordable Care Act for the state of Indiana.

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

Medically Necessary – those Health Care Services that we determine to be all of the following.

(4) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the Covered Person's illness, injury or disease.

(5) Required for the direct care and treatment or management of the Covered Person's illness, injury or disease.

(6) If not provided, the Covered Person's condition would be adversely affected.

(7) Provided in accordance with generally accepted standards of medical practice.

(8) Not primarily for the convenience of the Covered Person, your family, the physician or another prescribing Provider.

(9) 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 Covered Person'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 Covered Person'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 used in this 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 – 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 this Contract.

Non-Participating Hospital – a Hospital that has not entered into a contractual agreement with us or is not otherwise engaged by us to provide Health Care Services to Covered Persons under this 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 Covered Persons under this Contract.

[**Open Enrollment Period** – the number of days each year during which individuals may enroll in a Qualified Health Plan through the Indiana Marketplace.]

[**Open Enrollment Period** – the number of days each year during which individuals may enroll for coverage under this Contract.]

Out of Pocket Maximum – the maximum amount you will pay for Covered Services in a Plan Year.

Outpatient – receipt of Health Care Services while not an Inpatient.

Participating Hospital – a Hospital 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 Covered Persons under this Contract.

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 Covered Persons under this Contract.

Plan Year – the calendar year during which this Contract is in effect. This Plan Year will be the 12 month calendar year except that if the Subscriber's Effective Date is after January 1st the Plan Year will begin on the Effective Date and end December 31st.

Precertification – 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.

Prescription Drug – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product, insulin, diabetic supplies, and syringes.

Prescription Legend Drug – A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

Primary Care Physician or 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 a Covered Person's medical care under this Contract.

Provider – a doctor, Hospital, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

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.

(1) The Health Care Service that is the subject of the Approved Clinical Trial.

(2) 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.

(3) 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.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) 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.

(6) A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.

(7) A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Qualified Health Plan – a health plan offered on the Indiana Marketplace that satisfies the requirements set forth under the Affordable Care Act (42 U.S.C. 18021(a)(1)).

[**Qualified Individual** – an individual who has been determined by the Indiana Marketplace to be eligible to enroll in a Qualified Health Plan.]

Schedule of Benefits – the part of this Contract that sets forth Cost Sharing, Out of Pocket Maximums, limitations and other information regarding a Covered Person's coverage under this Contract.

Service Area – the counties in which we are authorized to offer a qualified health plan. Our Service Area is [insert list of counties].

Sickness – a physical illness, disorder, or disease.

Deleted: Sickness does not include Behavioral Health conditions.

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.

[**Special Enrollment Periods** – enrollment periods administered by the Indiana Marketplace that occur outside of the Open Enrollment Period. Qualified Individuals and their dependents who are eligible for a Special Enrollment Period may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another during a Special Enrollment Period set for them by the Indiana Marketplace.]

[**Special Enrollment Periods** – enrollment periods administered by us that occur outside of the Open Enrollment Period.]

Spouse – the Subscriber's legal spouse.

Subscriber – an individual whose name is on the Contract and has enrolled a Dependent for coverage under this Contract. A Subscriber is the legal parent or legal guardian of the Covered Person. The Subscriber is not a Covered Person under this Contract.

Therapeutic Abortion – an abortion performed to save the life or health of the mother, or as a result of incest or rape

Urgent Care Claim – 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 a Covered Person's life, health or ability to reach and maintain maximum function.
- In the opinion of physicians familiar with a Covered Person's condition, would subject a Covered Person to severe pain that cannot be adequately managed unless we approve the Claim.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT.

[This Contract is available through the Indiana Marketplace. The Benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Indiana Marketplace to be Qualified Individuals.]

A. **The Covered Person as an Individual:** To be eligible for coverage as a Subscriber, an individual must meet the eligibility requirements listed below at the time of application and throughout the Plan Year.

(1) [Determined by the Indiana Marketplace to be a Qualified Individual for purposes of enrollment in a Qualified Health Plan.] [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective.]

(2) [Not incarcerated.] [Agree to pay the cost of the Premium that we require.]

(3) [A United States citizen or lawfully present non-citizen.] [Submit proof satisfactory to us to confirm Dependent eligibility.]

(4) To be eligible as a Dependent, the person must be the Subscriber's Child.

(5) Under age 21.

(6) A resident of the State of Indiana.

(7) Not entitled to or enrolled in Medicare or Medicaid.

(8) Not covered by any other group or individual health benefit plan.

B. [**Other Rules About Eligibility.** No one will be denied enrollment or re-enrollment in this Contract because of health status, or the existence of a pre-existing physical or mental condition.]

C. **Open Enrollment**.

(1) [Notice of Annual Open Enrollment. Each calendar year the Indiana Marketplace will provide you with a written annual open enrollment notification no earlier than September 1, and no later than September 30.]

[Notice of Annual Open Enrollment. Each calendar year we will provide you with a prior written notice of the Open Enrollment Period.]

(2) [2015 Open Enrollment Period. For this Plan Year beginning on January 1, 2015, the Open Enrollment period begins on November 15, 2014 and extends through February 15, 2015.]

(3) [Effective Dates for Coverage Selected During 2015 Open Enrollment. For this Plan Year beginning on January 1, 2015, the following Effective Dates will apply:

(a) January 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace on or before December 15, 2014.

(b) February 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from December 16, 2014 through January 15, 2015.

(c) March 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from January 16, 2015 through February 15, 2015.]

(4) [Effective Dates for Coverage Selected During Annual Open Enrollment. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if we receive the application and initial premium payment between the 1st and 15th of the month. If we receive the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st)]

D. [**Special Enrollment Period.**

(1) Special Enrollment Triggering Events. The Indiana Marketplace must allow Qualified Individuals and Dependents to enroll in a Qualified Health Plan or change from one Qualified Health Plan to another as a result of experiencing any of the following triggering events:

(a) Loss of Minimum Essential Coverage.

(b) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(c) Gaining status as a citizen, national, or lawfully present individual.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services ("HHS"), or its instrumentalities as evaluated and determined by the Indiana Marketplace. In such cases, the Indiana Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to a new service area of the Indiana Marketplace.

(h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(i) Demonstration to the Indiana Marketplace, in accordance with guidelines issued by HHS, that the Dependent meets other exceptional circumstances as the Indiana Marketplace may provide.

(j) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.)

(2) Indiana Marketplace Administration of Special Enrollments. For additional information on special enrollment triggering events and how to enroll in or change a Qualified Health Plan during a Special Enrollment Period, you should contact the Indiana Marketplace at [toll free number] or visit the Indiana Marketplace website at [www.healthcare.gov].

(3) Notice Requirement for Special Enrollments. Unless specifically stated otherwise in the applicable Indiana Marketplace rules, a person has sixty (60) days from the date of a special enrollment triggering event to select a Qualified Health Plan.

(4) Special Enrollment Effective Dates. The Effective Date for coverage obtained under this Contract during a Special Enrollment Period depends on the type of triggering event that qualified the individual and/or dependent for the Special Enrollment Period as well as the date the Indiana Marketplace received the Qualified Individual's Qualified Health Plan selection.

(a) For a Qualified Health Plan selection received from the first (1st) through the fifteenth (15th) day of any month, the Effective Date will be the first (1st) day of the following month; and

(b) For a Qualified Health Plan selection received from the sixteenth (16th) through the last day of any month, the Effective Date will be the first (1st) day of the second following month.]

D. [**Changes Affecting Eligibility and Special Enrollment Periods.**

(1) Special Enrollment Triggering Events. A Special Enrollment Period is a period during which an eligible individual who experiences certain triggering events or changes in eligibility may enroll in this Contract, outside of the Open Enrollment period.

(2) Length of Special Enrollment Period. Unless otherwise stated, an eligible individual has 60 days from the date of a triggering event to enroll an eligible individual in this Contract.

(3) Triggering Events

(a) Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, misrepresentation of a material fact or failure to pay premium.

(b) Loss of Minimum Essential Coverage due to dissolution of marriage.

(c) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Indiana Marketplace.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to new service area of the Indiana Marketplace.

(h) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.]

E. Adding New Dependents Under A Special Enrollment Period

(1) Newly Born Children. If the Subscriber has a new Dependent as a result of birth, coverage for the new Dependent is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for the new Dependent shall continue beyond the initial thirty-one (31) days, provided the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace to add the new Dependent to this Contract] [submits a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, if any[, within 60 days after the birth of the new Dependent]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days after the date of birth. The Effective Date will be the date of birth.]

If a Covered Person has a newborn child, coverage for the newborn child is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for the newborn child shall continue beyond the initial thirty-one (31) days, provided the newborn child meets the definition of Child under this Policy

and the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace] [submits a form to us] to add the Child to this Contract and we receive payment for additional applicable premium, if any. If the newborn child does not meet the definition of Child under this Policy before the end of the initial thirty-one (31) days, coverage for the newborn child will terminate upon the thirty-second (32nd) day.

(2) Adopted Children. If the Subscriber has a new Dependent as a result of adoption, coverage for the new Dependent is automatically provided from the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the Subscriber custody of the child for purposes of adoption, for up to thirty-one (31) days. Coverage for the new Dependent shall continue beyond the initial thirty-one (31) day period provided the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace to add the new Dependent to this Contract] [submits a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, in any[, within 60 days following the date of adoption or placement for adoption]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of adoption or placement of adoption.] The Effective Date will be the earlier of the date of adoption or placement of adoption.

(3) Adding a Child due to Award of Guardianship. If the Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a Child, an application to cover the Child under this Contract must be submitted to [the Indiana Marketplace] [us] within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

(4) Qualified Medical Child Support Order. If the Subscriber is required by a Qualified Child Support Order or court order, as defined by applicable state and federal law, to enroll his or her Child under this Contract, and the Child is otherwise eligible for the coverage, [the Indiana Marketplace] [we] will permit the Subscriber's Child to enroll in this Contract, and we will provide the benefits of this Contract in accordance with the applicable requirements of such court order.

A Child's coverage under this provision will not extend beyond the Dependent attaining age 26. Any claims payable under this Contract will be paid, at our discretion, to the Child or the Child's custodial parent or legal guardian, for any expenses paid by the Child, custodial parent or legal guardian. We will make information available to the Child, custodial parent or legal guardian on how to obtain benefits and submit claims to us directly.

(5) New Dependent as a Result of Marriage or Loss of Minimum Essential Coverage. If the Subscriber has a new Dependent as a result of marriage, or due to the new Dependent's loss of Minimum Essential Coverage, the Subscriber may elect to enroll the new Dependent in this Contract, provided the Subscriber [requests a Special Enrollment Period from the Indiana Marketplace to add your new Dependent to this Contract] [submits to us a form to add your new

Dependent] and we receive payment for additional applicable premium, if any[, within 60 days from the date of marriage or the loss of Minimum Essential Coverage]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of marriage or the loss of Minimum Essential Coverage.] The Effective Date will be on the first (1st) day of the month following the date of marriage or loss of Minimum Essential coverage.

(a) "Loss of Minimum Essential Coverage" includes loss of eligibility for coverage as a result of any of the following:

(a) Legal separation or divorce.

(b) Cessation of dependent status (such as reaching the maximum age to be eligible as a Dependent under this Contract).

(c) Death of an employee; termination of employment; reduction in the number of hours of employment; or any loss of eligibility for coverage after a period that is measured by any of the foregoing.

(d) Individual who no longer resides, lives or works in the service area.

(e) A situation in which a health benefit plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Termination of employer contributions.

(g) Exhaustion of COBRA continuation of coverage.

(b) "Loss of Minimum Essential Coverage" does not include termination or loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(b) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact

If the Subscriber does not enroll a new Dependent during the time periods stated above, the new Dependent will not be added to the coverage under this Contract until the next Open Enrollment Period.

F. Notification of Changes.

(1) Responsibility to Notify [the Indiana Marketplace] [Us]. The Subscriber is required to notify [the Indiana Marketplace] [us] of any changes in a Covered Person's eligibility for Benefits under this Contract. [The Indiana Marketplace] [We] must be notified of any changes in eligibility as soon as possible, but not later than thirty (30) days from the date of the change in eligibility status. This

may include changes in address, marriage, divorce, death, incarceration, change of Dependent disability or dependency status, change in Medicare or Medicaid eligibility status, etc. Notice of a change in eligibility must be provided to [the Indiana Marketplace in a form required and approved by the Indiana Marketplace] [us in writing and on a form approved by us]. Such notifications must include all information required to effectuate all necessary changes.

(2) Failure to Notify [Indiana Marketplace] [Us]. Failure to notify [the Indiana Marketplace] [us] of persons no longer eligible for coverage under this Contract will not obligate us to provide services to those no longer eligible. Our acceptance of payments for persons no longer eligible for services will not obligate us to pay for such services.

(3) Effective Date of Termination Due to Change in Eligibility. Regardless of whether we receive timely notice, a Covered Person's coverage will terminate on the [last day of the month following the date] [day] such Covered Person ceases to be eligible for coverage under this Contract. [We have the right to bill the Subscriber for the cost of any Health Care Services provided to a Covered Person during the period such Covered Person is not eligible under this Contract.] If the Subscriber thinks there are reasons coverage of the person experiencing the change should continue, the Subscriber must notify [the Indiana Marketplace] [us] of the reasons for the continuation of the coverage no later than thirty-one (31) days after the date coverage for the Dependent would otherwise terminate.

(4) [Statements and Forms. You shall complete and submit to us applications and other forms or statements we may request. You represent to the best of their knowledge and belief that all information contained in such applications, forms, questionnaires, and statements submitted to us is true, correct and complete. You understand that all rights to Benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you or a Covered Person may result in termination or rescission of coverage.]

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A. Premium

(1) The Subscriber must pay premium to us each month for coverage under this Contract. The Subscriber's premium rate is determined using the following acceptable rating factors: age, tobacco use, family size and geography.

(a) Tobacco use impacts the determination of the premium. [Upon enrollment through the Indiana Marketplace] [During the enrollment application process], the Subscriber will attest to tobacco use by his or her Dependents. If the Subscriber reports false or incorrect information about tobacco use, we may retroactively apply the appropriate tobacco rating factor to the Subscriber's premium as if the correct information had been accurately reported from the Effective Date.

(b) A Covered Person's age impacts the determination of the premium rate. If a Covered Person's age has been misstated, we will adjust the premiums to the amount premiums would have been if purchased at the correct age.

(2) The Subscriber will receive a monthly bill for your premium. The Subscriber's payment is due by the date stated in the Subscriber's bill subject to the any applicable Grace Period stated in this Contract. The Subscriber must pay the premium when it is due for coverage to continue.

(3) We reserve the right to change the premium on an annual basis. We will provide the Subscriber with thirty (30) days prior written notice of any change in the premium.

(4) The Subscriber's premium may change if Dependents are enrolled or disenrolled in the coverage under this Contract. If a premium increase is necessary, we will bill the Subscriber for the additional amount due. If this amount is not paid, this Contract will be cancelled at the end of the applicable Grace Period and the Subscriber will receive a refund of any unearned premium. If a decrease in premium is appropriate we will notify the Subscriber of the decrease and refund any excess premium to the Subscriber.

(5) If premium has been paid for any period of time after the date the Subscriber cancels this Contract, we will refund that premium to the Subscriber. The refund will be for the period of time after coverage under this Contract ends. If a Covered Person dies while this Contract is in force, we will refund any premium paid for such Covered Person for any period after the date of the Covered Person's death.

B. Grace Period

(1) [General Grace Period.] Following payment of the initial premium, a Grace Period of thirty (30) days shall be granted for the payment of any premium. This Grace Period shall not extend beyond the date this Contract terminates. During

the Grace Period this Contract shall continue in force. Any claims incurred and submitted during the Grace Period will not be considered for payment until premium is received. If premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of coverage.

(2) [Grace Period for Persons Receiving Advance Payments of the Premium Tax Credit. If the Subscriber or Covered Person is receiving advance payments of the premium tax credit and at least one full month's premium has been paid during this Plan Year, a Grace Period of three (3) consecutive months shall be granted for the payment of any premium. During this 3-month Grace Period, we shall do all of the following listed below.

(a) Pay for Covered Services during the first (1st) month of the Grace Period and may pend claims for Covered Services rendered to the Covered Person in the second and third months of the Grace Period.

(b) Notify the Department of Health and Human Services of such non-payment

(c) Notify Providers of the possibility for denied claims during the second and third months of the Grace Period.]

C. Deductible.

(1) The Deductible is the amount the Subscriber must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The Deductible is set forth in the Schedule of Benefits.

(2) Copayments do not count towards the Deductible.

D. Coinsurance

(1) Coinsurance is a percentage of the Allowed Amount that the Subscriber must pay for Covered Services. The Subscriber is responsible for payment of Coinsurance after the Subscriber has met the Deductible and until the Subscriber reaches the Out of Pocket Maximum. Coinsurance is set forth in the Schedule of Benefits.

(2) Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

E. Copayments

(1) Copayments are a fixed amount the Subscriber pays to a Provider for a Covered Service. Copayments are typically paid when the Subscriber receives the Covered Service. The amount of the Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

(2) Copayments do not apply to the Deductible. Copayments apply towards the Out of Pocket Maximum.

F. Out of Pocket Maximum

(1) The Out of Pocket Maximum is the maximum amount the Subscriber will pay for Covered Services in a Plan Year. The Out of Pocket Maximum is listed on the Schedule of Benefits.

(2) Once the Out of Pocket Maximum is reached, we will pay 100% of the Benefits for Covered Services.

(3) Copayments, Coinsurance and the Deductible apply towards the Out of Pocket Maximum.

G. Payments for Non-Covered Services. The Subscriber is responsible for payment of all expenses for Non-Covered Services.

ARTICLE 4. COVERED SERVICES

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides Benefits for the following Covered Services. Payment for Covered Services is limited by any applicable Coinsurance, Copayment, or Deductible set forth in this Contract including the Schedule of Benefits. To receive maximum Benefits for Covered Services, the terms of this Contract must be followed, including receipt of care from a Primary Care Physician and Participating Providers as well as obtaining any required Precertification.

You are responsible for all expenses incurred for Non-Covered Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

A. Ambulance Services

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

(a) From your home, scene of accident or medical Emergency to a Hospital,

(b) Between Hospitals,

(c) Between a Hospital and Skilled Nursing Facility, or

(d) From a Hospital or Skilled Nursing Facility to your home.

(2) Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

(3) Other vehicles which do not meet the definition of Ambulance Services are not Covered Services. Ambulette services are Covered Services when appropriate.

(4) Ambulance Services are a Covered Service only when Medically Necessary, except:

(a) When ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse, or

(b) When a Covered Person is required by us to move from a Non-Participating Provider to a Participating Provider.

(5) Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health.

(6) Non-Covered Services for Ambulance include but are not limited to:

(a) A trip to a physician's office or clinic,

(b) A trip to a morgue or funeral home, or

(c) Any ambulance usage for the convenience of a Covered Person, family or Provider.

B. Behavioral Health Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Covered Services include:

(a) Inpatient services. Individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

(b) Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

(c) Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health conditions. Intensive Outpatient programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient programs may offer group, DBT, individual, and family services.

(d) Outpatient Treatment, or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

(2) Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

(3) To assist you in obtaining appropriate and quality care, we will ask for a treatment plan after you have been evaluated after 10 Outpatient visits. We may discuss the goals of treatment and changes in the treatment plan, including

alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

(4) Non-Covered Services include the following.

(a) Custodial or domiciliary care.

(b) Supervised living or halfway houses.

(c) Services or care provided or billed by a residential treatment center, school, halfway house.

(d) Custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(e) Services related to non-compliance of care if the Covered Person ends treatment for substance abuse against the medical advice of the Provider.

C. Routine Care Costs as Part of a Cancer or Other Life Threatening Disease or Condition Clinical Trial

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits are available for Routine Care Costs rendered as part of an Approved Clinical Trial if the services are otherwise Covered Services under this Contract.

(2) Your Primary Care Physician must give us notice of your participation in an Approved Clinical Trial.

(2) Non-Covered Services include the following.

(a) A Health Care Service that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient.

(b) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service or investigational drug that is the subject of the clinical trial.

(c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.

(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the clinical trial.

(e) An item or drug provided by the clinical trial sponsors free of charge for any patient.

(f) A service, item, or drug that is eligible for reimbursement by a person or entity other than us, including the sponsor of the clinical trial.

D. Dental Services Related to an Injury

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient services, Physician Home Visits and Office Services, Emergency Services and Urgent Care Center Services for dental work and oral surgery are Covered Services if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Covered Person's condition.

(2) Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

(3) For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

(4) Covered Services include, but are not limited to the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations
- Prosthetic services
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia

(5) Anesthesia and Hospital charges for dental care for a Covered Person less than 19 years of age or a Covered Person who is physically or mentally disabled, are covered if the Covered Person requires dental treatment to be given in a Hospital or Outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Covered Person's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

E. Diabetic Equipment, Education and Supplies

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when ordered in writing by a physician or a podiatrist and provided by a physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

(2) Covered Services include physician prescribed equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical Equipment and Appliances", "Preventive Care Services", and "Physician Home Visits and Office Services".

F. Diagnostic Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services include the following.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).

- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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

(3) For Diagnostic services other than those approved to be received in a physician's office, you may be required to use a laboratory that is a Participating Provider.

(4) When Diagnostic radiology is performed in a Participating Provider's Office, no Copayment is required, however, any Coinsurance will still apply.

G. Emergency Care Services and Urgent Care Center Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit limitation. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits for treatment of an Emergency Medical Condition and Emergency screening and stabilization services without Precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions.

(2) Benefits for Emergency Care include facility costs and physician services, supplies and Prescription Drugs charged by that facility.

(3) Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Copayment or Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify us or verify that your physician has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary. If your Provider is a Non-Participating Provider, you will be financially responsible for any care we determine is not Medically Necessary.

(4) Often an urgent rather than an Emergency Medical Condition exists. An urgent medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Such medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Primary Care Physician prior to receiving care for an urgent medical problem and your Primary Care Physician

authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Care Services.

H. Home Care Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Covered Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Care Services.
- Nutritional Guidance.
- Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Health Care Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Care Services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services in the home (except for Massage, Music, and Manipulation Therapy). Home Care visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

(3) Non Covered Services include the following.

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

(4) Home infusion therapy will be paid only if you obtain Precertification. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

I. Hospice Services

For all Covered Services, see the schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit limitations. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) 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 (6) months or less, as certified by the attending physician and hospice medical director. Covered Services will continue if the Covered Person lives longer than six (6) months, provided the hospice medical director or other hospice physician recertifies that the Covered Person is terminally ill.

(2) Covered Hospice Services include the following.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Care Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

(3) Non-Covered Services include services provided by volunteers and housekeeping services.

J. Inpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Inpatient services include the following.

(a) Charges from a Hospital, Skilled Nursing Facility or other Provider for room, board and general nursing services.

(b) Ancillary services.

(c) Professional services from a physician while an Inpatient.

(2) Room, Board, and General Nursing Services include either of the following.

(a) A room with two or more beds or a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

(b) A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

(3) Ancillary (Related) Services include any of the following.

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

(4) Professional Services include the following.

- Medical care visits limited to one visit per day by any one physician.
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, and EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

(5) When a Covered Person is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

K. Maternity Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

(2) If the Covered Person is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider for the Health Care Services to be Covered Services. If the Covered Person is pregnant on her Effective Date and is in her second or third trimester of pregnancy, she may receive Benefits for Health Care Services from a Non-Participating Provider if she requests and receives written approval from us.

(3) If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance or Copayment.

(4) If Maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

(5) Coverage for the Inpatient postpartum stay for a Covered Person and her newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if both or the following are met.

(a) In the opinion of your attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the following.

- The antepartum, intrapartum, and postpartum course of the mother and infant.
- The gestational stage, birth weight, and clinical condition of the infant.
- The demonstrated ability of the mother to care for the infant after discharge.
- The availability of post discharge follow-up to verify the condition of the infant after discharge.

(b) The mother of the newborn child agrees with the recommendation for a shorter length of stay.

(6) Covered Services include at-home post-delivery care visits at your residence by a physician or nurse performed no later than 48 hours following discharge from the Hospital. Coverage for this visit includes, but is not limited to parent education, assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At your discretion, this visit may occur at the physician's office.

(7) Covered Services include the following tests and examinations given at the earliest feasible time to the newborn child for the detection of the following disorders.

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

L. Medical Supplies, Durable Medical Equipment and Appliances

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Medical and Surgical Supplies. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a physician's office, including but not limited to, Depo-Provera and Remicade. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

(a) Covered Services include the following.

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.

- Clinitest.
- Needles/syringes.
- Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not Covered Services.

(b) Non-Covered Services include the following.

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Medijectors.

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

(3) Durable Medical Equipment - The rental (or, at our option, the purchase) of Durable Medical Equipment prescribed by a Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples of Durable Medical Equipment include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price.

(a) We will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Covered Person, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is a Covered Service.

(b) Covered Services include the following.

- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pump for IV fluids and medicine.
- Glucometer.

- Tracheotomy tube.
- Cardiac, neonatal and sleep apnea monitors.
- Augmentive communication devices are Covered Services when we approve based on the Covered Person's condition.
- CPAP machines when indicated for sleep apnea.

(c) Non-Covered Services include the following.

- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats.
- Rental of equipment if the Covered Person is in a Facility that is expected to provide such equipment.
- Translift chairs.
- Treadmill exerciser.
- Tub chair used in shower.

(4) Prosthetics. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

(a) Prosthetic devices should be purchased not rented. Applicable taxes, shipping and handling are Covered Services.

(b) Covered Services include the following.

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Plan Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction

is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered Services. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be a Covered Service.

- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Plan Year).

(c) Non-Covered Services include the following.

- Dentures, replacing teeth or structures directly supporting teeth.
- 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.

(5) Orthotic Devices. The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered Services. The casting is a Covered Service when an orthotic appliance is billed with it, but not if billed separately.

(a) Covered Services include the following.

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

(b) Orthotic appliances may be replaced one time per Plan Year unless specifically approved in writing by us. Additional replacements will be allowed for Covered Persons under age 18 due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

(c) Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

(d) Non-Covered Services include the following.

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

(6) Prosthetic limbs & Orthotic custom fabricated brace or support. Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be a Covered Service if they are determined by your physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities, and are not solely for comfort or convenience.

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

(b) Prosthetic limbs and orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

(7) Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below, as approved by us.

(a) The repair, adjustment or replacement of the purchased equipment, supply or appliance is a Covered Service if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.

- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

(b) Replacement of purchased equipment, supplies or appliance may be a Covered Service if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

(c) Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

M. Outpatient Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital or other facility as determined by us. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation.

(2) Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to Article 3 Section B for Behavioral Health Services covered by this Contract.

(3) Professional charges only include services billed by a physician or other professional.

(4) When Diagnostic Services or other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Service, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

(5) For Emergency Care refer to the section titled Emergency Services.

N. Autism Spectrum Disorder Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Autism Spectrum Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(2) Coverage is provided for the treatment of Autism Spectrum Disorders, including behavioral therapies such as Applied Behavior Analysis (ABA). Benefits are limited to Health Care Services prescribed by your physician in accordance with a treatment plan. Coverage for Health Care Services will be provided as prescribed by your treating physician in accordance with the treatment plan.

(3) Any exclusion or limitation in this Contract in conflict with the coverage described in this section will not apply.

(4) Coverage for Autism Spectrum Disorders will not be subject to limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Contract.

O. Physician Home Visits and Office Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service a Health Care Service must be Medically Necessary.

(1) Covered Services include care provided by a physician, including employees of the physician such as an advanced practice nurse or physician assistant, in his/her office or your home. Refer to the sections titled Preventive Care, Maternity Care, Home Care Services, and Behavioral Health Care Services for services covered by this Contract. For Emergency Care refer to the Emergency Services section.

(2) Office visits for medical care and consultations to examine, diagnose, and treat a Sickness or injury performed in the physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a physician's office, no Copayment is required however Coinsurance will apply.

(3) Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

(4) Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

(5) Surgery and surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

(6) Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a physician or other professional Provider.

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

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

(2) Preventive Care Services in this section shall meet requirements as determined by federal and state law.

(a) Health Care Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF. Covered Services include the screenings for following.

- Breast cancer.
- Cervical cancer.
- Colorectal cancer.
- High Blood Pressure.
- Type 2 Diabetes Mellitus.
- Cholesterol.
- Child and Adult Obesity.
- For Covered Persons age 15 – 65 and other ages at increased risk, Human Immunodeficiency Virus (HIV)
- Depression for adults
- Screening for alcohol misuse

(b) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(c) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Well Baby visits and care.
- Newborn screening for hearing
- Lead screening for children at risk for exposure
- Depression screening for adolescents

(d) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Women's contraceptives, sterilization procedures, and counseling. This includes generic drugs only, unless there is no generic equivalent, obtained from a Participating Pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms and intrauterine devices (IUDs) are also covered. When generic equivalents are available, prescription brand name contraceptives will not be covered under the Preventive Care benefit. Instead, prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the Prescription Drug Benefits section.
- Breastfeeding support, supplies, and counseling.
- Gestational diabetes screening.

(3) Covered Services also include the following services required by state law:

(a) Breast Cancer Screening. The following are Covered Services.

(a) If the female Covered Person is at least 35 years of age, one (1) baseline breast cancer screening mammography performed before she becomes 40 years of age.

(b) If the female Covered Person is less than 40 years of age and is high risk, one (1) breast cancer screening mammography performed every year. A woman is considered "high risk" if she meets at least one (1) of the following.

(A) Has a personal history of breast cancer.

(B) Has a personal history of breast disease proven benign by biopsy.

(C) Has a mother, sister, or daughter who has had breast cancer.

(D) Is at least 30 years of age and has not given birth.

(c) Any additional mammography views that are required for proper evaluation.

(d) Ultrasound services, if determined Medically Necessary by the physician treating the Covered Person.

(b) Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Service for a Covered Person under the age of fifty (50) if the Covered Person is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsymptomatic Covered Person, in accordance with the current American Cancer Society guidelines.

(c) Diagnostic Prostate Cancer Screening. If male Covered Person is at least 50 years of age, one (1) prostate specific antigen test annually is a Covered Service. If a male Covered Person is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test annually is a Covered Service.

Q. Surgical Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes the following.

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

(2) The surgical fee includes normal post-operative care.

(3) We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact us for more information.

(4) Covered Surgical Services include the following.

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

R. Reconstructive Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

(2) Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract.

(3) Covered Services are limited to the following.

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

(4) For a Covered Person who has undergone a mastectomy Covered Services include the following.

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

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S. Sterilization.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

Sterilization is a Covered Service.

T. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

(2) Covered Services include removable appliances for repositioning and related surgery, medical care, and diagnostic services.

(3) Non-Covered Services include the following:

- Fixed or removable appliances that involve movement or repositioning of the teeth.
- Repair of teeth (fillings).
- Prosthetics (crowns, bridges, dentures).

U. Therapy Services.

Benefits are provided for therapy services that can be Rehabilitative or Habilitative. For purposes of this section and the Schedule of Benefits, the following definitions apply:

- Rehabilitation refers to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech therapy and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Physical therapy.

(a) Physical therapy includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve

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

(b) Non-Covered Services include the following.

- 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.

Deleted: <#>Maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness.¶

(3) Speech Therapy. Speech therapy for the correction of a speech impairment.

(4) Occupational Therapy. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

(a) Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

(b) Non-Covered Services include the following.

- Supplies (looms, ceramic tiles, leather, utensils).
- Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again.
- General exercises to promote overall fitness and flexibility.
- Therapy to improve motivation.
- Suction therapy for newborns (feeding machines).
- Soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial.
- Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

(5) Manipulation Therapy. Manipulation Therapy includes osteopathic/chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

(a) Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any limitation for Manipulation Therapy services as specified in the Schedule of Benefits.

(b) Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

(6) Other Therapy Services

(a) Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

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

(c) Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage this Contract will not require you to receive dialysis treatment at a Participating Provider that is a dialysis facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Participating Dialysis Facility is more than 30 miles from your home, you may, upon our prior written consent, receive treatment at a Non-Participating Provider that is a dialysis facility nearest to your home as Covered Service.

(d) Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

(e) Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to:

- Introduction of dry or moist gases into the lungs.
- Nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication.
- Continuous positive airway pressure ventilation (CPAP).
- Continuous negative pressure ventilation (CNP).
- Chest percussion.
- Therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers.
- Broncho-pulmonary drainage.
- Breathing exercises.

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

V. Physical Medicine and Rehabilitation Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

(2) The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting. Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

(3) Non-Covered Services include the following.

- Admission to a Hospital mainly for physical therapy.
- Long term rehabilitation in an Inpatient setting.

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

W. Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Cost Sharing.

(2) "Covered Transplant Procedure" includes any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

(3) "Transplant Benefit Period" starts one day prior to a covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.

(4) Transplant services require Precertification.

(5) Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are a Covered Service as routine Diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

(6) Transportation and Lodging. This Contract will provide assistance with reasonable and necessary travel expenses as determined by us when you obtain Precertification and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when claims are filed.

(7) Non-Covered Services for transportation and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

X. Prescription Drug Benefits

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Pharmacy Benefits Manager (PBM).

(a) The Prescription Drug benefits are managed by our Pharmacy Benefits Manager or PBM. The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy, a Specialty Pharmacy, and provides clinical management services. The management and other services the PBM provides include, making recommendations to, and updating, the "covered Prescription Drug list" (the "covered Prescription Drug list" is referred to as the "Formulary"), managing a network of retail pharmacies, operating a mail service pharmacy, and operating a Specialty Pharmacy network.

(b) The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of Prescription Drug benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions or drug/pregnancy concerns. You may request a copy of the Formulary by calling the Customer Service telephone number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage.

(c) For certain Prescription Drugs, the prescribing Provider may be asked to provide additional information before the PBM and/or we can determine Medical Necessity. We may, in our sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer.

(d) Precertification may be required for certain Prescription Drugs (or the prescribed quantity of a particular Prescription Drug). At the time you fill a prescription, the Participating Pharmacy is informed of the Precertification requirement through the Participating Pharmacy's computer system. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee which is reviewed and adopted by us.

(e) For a list of the current Prescription Drugs requiring Precertification, please contact the Customer Service telephone number on the back of your Identification Card or go to our website at [insert url to formulary]. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage. Your Provider or Participating Pharmacy may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under this Contract.

(2) Therapeutic Substitution of Prescription Drugs. This is a voluntary program designed to inform Covered Persons and Providers about possible substitutes to certain Prescription Drugs. We, or the PBM, may contact you and your prescribing Provider to make you aware of substitution options. Therapeutic substitutes may also be initiated at the time the Prescription Drug is dispensed.

(a) Only you and your Provider can determine whether the therapeutic substitute is appropriate for you.

(b) For questions or issues involving therapeutic substitutes, call the Customer Service telephone number on the back of your Identification Card.

(c) The therapeutic substitutes list is subject to periodic review and amendment.

(3) Step Therapy. Step therapy protocol means that a Covered Person may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Covered Persons access high quality yet cost effective Prescription Drugs. If a Provider decides that the monitored medication is needed the Precertification process is applied.

(4) Participating Specialty Pharmacy. The PBM's Specialty Pharmacy is available to Covered Persons who use Specialty Drugs.

(a) "Specialty Drugs" are Prescription Legend Drugs that are one of the following:

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

(b) Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, subject to a day supply limit for retail and mail service, and the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

(c) Questions regarding Specialty Drugs can be directed to the Customer Service telephone number on the back of your Identification Card.

(d) You may obtain a list of the Participating Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your Identification Card, or review the lists on our website at [insert address].

(5) Covered Services include the following.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Self-administered contraceptives, including oral contraceptives, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the Preventive Care section, please see that section for more details.
- Selected drugs to eliminate or reduce dependence on, or addiction to tobacco and tobacco products.
- Injectables.
- Selected preventive medications are covered with no Copayment or Coinsurance if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations. These medications include the following: vitamin D supplementation, folic acid supplementation, aspirin and oral fluoride supplementation.

(6) In addition to the Exclusions set forth in Article 4, Non-Covered Services include the following.

- Prescription Drugs dispensed by any mail service program other than the PBM's mail service pharmacy, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.

- Off label use, except as otherwise prohibited by law or as approved by us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription.
- Drugs not approved by the FDA except as otherwise prohibited by law.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a physician. This does not apply to drugs used in conjunction with a Diagnostic Service, with chemotherapy performed in the office or drugs eligible for coverage under the Medical Supplies benefit.
- Any drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by this Contract, or which exceed any age limits established by us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility drugs.
- Human growth hormone for children born small for gestational age.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact us for additional information on these Prescription Legend Drugs.
- Refills of lost or stolen medications.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, unless otherwise required by law or approved by us. "Clinically equivalent" means drugs that, for the majority of persons, can be expected to produce similar therapeutic outcomes for a disease or condition.

(7) If you have questions regarding whether a particular Prescription Drug is covered and which Tier a Prescription Drugs fall into, please call the Customer Service telephone number on the back of your Identification Card, or visit our website at [website address].

(8) Each Prescription Drug may be subject to a Deductible, Coinsurance or Copayment. If the prescription includes more than one covered Prescription Drug, a separate Coinsurance or Copayment will apply to each covered Prescription Drug. Your Copayment will be the lesser of your scheduled Copayment or the Allowable Amount.

(9) The number of days' supply of a Prescription Drug which you may receive is limited. The days' supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days' supply allowed for under this Contract, you should ask your Pharmacist

to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

(10) Your Copayment or Coinsurance amount may vary based on whether the Prescription Drug has been classified by us as a first, second, third, fourth or fifth "Tier" Prescription Drug. The determination of Tiers is made by us based upon clinical information, and where appropriate the cost of the Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

(a) Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This Tier will contain low cost and preferred generic medications as well as selected preventive medications that are covered with no Coinsurance or Copayment if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations.

(b) Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This Tier will contain non-preferred generic medications.

(c) Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This Tier will contain preferred brand name medications.

(d) Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This Tier will contain non-preferred brand name medications.

(e) Tier 5 Prescription Drugs will have a higher/comparative Coinsurance or Copayment than those in Tier 4. This Tier will contain medications that are considered Specialty Drugs.

We have established a Pharmacy and Therapeutics Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Precertification criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives. The Pharmacy and Therapeutics Committee also determines, where appropriate, the cost of a Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one drug over another in our patient program, and, where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by

mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

(11) From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, generic, mail service, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Prescription Drugs or preferred products for a limited period of time.

(12) The amount of Benefits paid is based upon whether you receive the Covered Services from a Participating Pharmacy, including a Participating Specialty Pharmacy, a Non-Participating Pharmacy, or the PBM's mail service program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug.

(13) How you obtain your Benefits depends upon whether you go to a Participating or a Non-Participating Pharmacy.

(a) Participating Pharmacy – Present your written prescription from your physician and your Identification Card to the pharmacist at a Participating Pharmacy. The Participating Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment or Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge and you believe the Prescription Drug should be covered, ask your pharmacist for an itemized receipt and submit it to us for reimbursement consideration.

(b) Specialty Drugs - You or your Provider can order your Specialty Drugs directly from a Participating Specialty Pharmacy, simply call the Customer Service telephone number on the back of your Identification Card. Your Specialty Drug may need Precertification prior to dispensing. Upon approval, your Specialty Drug will be delivered to your physician's office/your specified delivery location based on the physician's order. A clinician will be available to answer any questions you may have in regard to the Specialty Drug and the instructions.

(c) Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy, including a Non-Participating Specialty Pharmacy. You must submit a claim for reimbursement consideration as set forth in Article 8 Section C.

(d) The Mail Service Program – Complete the order and patient profile form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have your physician fax the prescription to the mail service pharmacy. Your physician may also phone in the prescription to the mail service pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the mail service pharmacy when you request a prescription.

(14) Drug Exception Program. This is a program designed to allow Covered Persons to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. Please call the Customer Service number on the back of your Identification Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or are currently undergoing a course of treatment using a Prescription Drug that is not on the Formulary, you may request an expedited review of your request for a drug exception. In such circumstances, we will provide you or your Designated Representative with our decision within twenty-four (24) hours after we receive your request.

Deleted: The Drug Exception Program is separate from and in addition to the benefit review and appeals processes outlined in Article 7.

Y. Pediatric Vision Services. The following Health Care Services are Covered Services only for Covered Person through the age of nineteen (19). The Contract only provides Benefits for vision care that is listed in this section.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A complete pediatric eye exam. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together. The exam may include the following.

- Case History.
- Cover test.
- Ocular Motility.
- Neurological Integrity.
- External Exam.
- Internal Exam.
- Retinoscopy.
- Phorometry testing.
- Point refraction.
- Tonometry.
- Opthalmoscopic exam.
- Confrontation Visual Fields.
- Biomicroscopy.
- Color Vision Testing.
- Diagnosis/Prognosis.
- Recommendations.

(2) Eyeglass Lenses. Lens options include a choice of plastic or polycarbonate. Lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include up to 55 mm in single vision, bifocal, trifocal or lenticular.

(3) Frames. This Contract offers a selection of frames that are covered.

(4) Contact Lenses. Coverage includes the following.

(a) Contact Lens professional fitting fees.

(b) Elective Contact Lenses (elective contact lenses are contacts that are chosen for comfort or appearance).

(c) Non-Elective Contact Lenses are only provided for the following medical conditions.

- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when the patient's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

(d) Medically Necessary contact lenses are available in lieu of ophthalmic lenses and may be subject to Copayments, Coinsurance and limitations. The Provider determines a patient's qualifying criteria at examination and evaluation, and will obtain any necessary Precertification from us for these services.

(5) Low Vision Benefits

(a) Comprehensive Low Vision Exam.

(b) Optical/Non-optical aids.

(c) Supplemental testing.

(6) Non-Covered Services include services incurred for, or in connection with, any of the items below.

- Non-elective contact lenses for any Covered Person who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- For safety glasses and accompanying frames.
- For Inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Covered Person has reached the normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Contract.

- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Vision services for Covered Persons over the age of nineteen (19) unless specifically stated in this Contract.

ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS

A. Non-Covered Services:

This Article 5 sets forth services that are excluded from coverage under this Contract and therefore are Non-Covered Services. Non-Covered Services are not covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

B. **Exclusions**. The following are Non-Covered Services:

(1) Services that we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.

(2) Services received from an individual or entity that is not a Provider.

(3) Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.

(4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

(5) Services provided as benefits by any governmental unit, unless otherwise required by law or regulation.

(6) Services for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

(7) Services for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

(8) Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

(9) Court ordered testing or care unless Medically Necessary.

(10) Services for which you have no legal obligation to pay in the absence of this or like coverage.

(11) Charges for consulting with Covered Persons by telephone, facsimile, electronic mail systems or other consultation or medical management service not involving

direct (face-to-face) care with the Covered Person except as otherwise described in this Contract.

(12) Surcharges for furnishing and/or receiving medical records and reports.

(13) Charges for doing research with Providers not directly responsible for your care.

(14) Charges that are not documented in Provider records.

(15) Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.

(16) Administrative or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

(18) Services prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

(19) Completion of claim forms or charges for medical records or reports unless otherwise required by law.

(20) Missed or canceled appointments.

(21) Mileage, lodging and meals costs, and other travel related expenses, except as authorized by us or specifically stated as a Covered Service in this Contract.

(22) Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.

(23) Services incurred prior to the Effective Date.

(24) Services incurred after the termination date of this coverage except as specified elsewhere in this Contract.

(25) For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Complications directly related to Cosmetic Services treatment or surgery, as determined by us, are not covered. This exclusion applies even if the original Cosmetic Services treatment or surgery was performed while the Covered Person was covered by another carrier/self-funded

plan prior to coverage under this Contract. "Directly related" means that the treatment or surgery occurred as a direct result of the Cosmetic Services treatment or surgery and would not have taken place in the absence of the Cosmetic Services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

(26) Maintenance Therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance Therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

(27) Custodial Care, convalescent care or rest cures.

(28) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

(29) Services provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

(30) Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

(31) Services or care provided or billed by a school, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(32) Wilderness camps.

(33) For routine foot care (including the cutting or removal of corns and calluses), Nail trimming, cutting or debriding, Hygienic and preventive maintenance foot care, including but not limited to 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.

(34) Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

(35) Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to the following.

- Extraction, restoration and replacement of teeth.

- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

(36) 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.

(37) Dental implants.

(38) Dental braces.

(39) Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following.

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer or cleft palate.

(40) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

(41) Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

(42) Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by us, are not covered. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(43) Marital counseling.

(44) Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

(45) Vision orthotic training.

(46) Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.

(47) Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

(48) Services to reverse voluntarily induced sterility.

(49) Diagnostic testing or treatment related to infertility.

(50) Personal hygiene, environmental control, or convenience items including but not limited to the following.

- Air conditioners, humidifiers, air purifiers.
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals.
- Charges for non-medical self-care except as otherwise stated.
- Purchase or rental of supplies for common household use, such as water purifiers.
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds.
- Infant helmets to treat positional plagiocephaly.
- Safety helmets for Covered Persons with neuromuscular diseases.
- Sports helmets.

(51) Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

(52) Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by us, or as otherwise described in this Contract.

(53) Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.

(54) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

(55) For self-help training and other forms of non-medical self-care, except as otherwise provided in this Contract.

(56) Examinations relating to research screenings.

(57) Stand-by charges of a Provider.

(58) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

(59) Services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

(60) Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Contract.

(61) Manipulation Therapy services rendered in the home as part of Home Care Services.

(62) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. This Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

(63) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

(64) Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

(65) Any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(66) Surgical treatment of gynecomastia.

(67) Treatment of hyperhidrosis (excessive sweating).

(68) Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by us through Precertification.

(69) Complications directly related to a service or treatment that is a Non-Covered Service under this Contract because it was determined by us to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

(70) Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

(71) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

(72) Treatment of telangiectatic dermal veins (spider veins) by any method.

(73) Reconstructive services except as specifically stated in this Contract or as required by law.

(74) Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

(75) For non-preventive medical nutritional therapy.

(76) Abortions that are not Therapeutic Abortions.

C. Experimental/Investigative Health Care Services Exclusion. We do not provide coverage for any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be Experimental/ Investigative.

(1) 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.

(a) 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 granted.

(b) Has been determined by the FDA to be contraindicated for the specific use.

(c) Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

(e) 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.

(2) Any Health Care Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by us. In determining whether a Health Care Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

(a) The scientific evidence is conclusory concerning the effect of the Health Care Service on health outcomes.

(b) The evidence demonstrates the Health Care Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects.

(c) The evidence demonstrates the Health Care Service has been shown to be as beneficial for the total population for whom the Health Care Service might be proposed as any established alternatives.

(d) The evidence demonstrates the Health Care Service has been shown to improve the net health outcomes of the total population for whom the Health Care Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(3) Off-Label Drug Treatment. Coverage for a drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

(a) The drug is recognized for treatment of the indication in at least one standard reference compendium.

(b) The drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the drug's use to be contraindicated or the drug has not been approved by the FDA for any indication.

(4) The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

(a) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.

(b) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.

(c) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Documents of an IRB or other similar body performing substantially the same function.

(e) Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(f) Medical records.

(g) The opinions of consulting Providers and other experts in the field.

ARTICLE 6. OBTAINING COVERED SERVICES

A. Participating Providers.

(1) Unless otherwise specifically provided in this Contract, in order to receive Benefits under this Contract, a Covered Person must receive Covered Services from a Participating Provider.

(2) The Covered Person is responsible for verifying that a Provider is a Participating Provider. A list of Participating Providers is available online at [insert website] or by calling us at [toll free number].

B. Non-Participating Providers. Health Care Services received from Non-Participating Providers are Non-Covered Services except for the following circumstances.

(1) Emergency Health Care Services.

(a) If we determine that the Health Care Services were not an Emergency, the Health Care Services are Non-Covered Services and you will be responsible for costs associated with the Health Care Services.

(b) Subsequent follow up care by a Non-Participating Provider after the condition is no longer an Emergency is a Non-Covered Service unless specifically authorized by us.

(c) If a Covered Person is hospitalized in a Non-Participating Hospital due to an Emergency, you or the Provider must notify us within 48 hours of the admission. A continued stay after the condition is stabilized and is no longer an Emergency requires our written authorization. We may elect to transfer the Covered Person to a Participating Hospital once it is medically appropriate to do so.

(2) Non-emergency Medically Necessary Health Care Services that cannot be provided by a Participating Provider and for which the Covered Person has obtained a Referral from his/her Primary Care Physician.

(3) Maternity services for a Covered Person who was in her second or third trimester of pregnancy as of her Effective Date as provided in Article 3 Section K.

(4) When our agreement with a Participating Provider terminates, upon your written request, the Covered Person may continue to receive Covered Services from the Provider for the following time periods.

(a) Up to sixty (60) days.

(b) In the case of Covered Person who is pregnant and in the third trimester of pregnancy, you may continue to receive Covered Services through the term of the pregnancy.

(c) For a Covered Person who is hospitalized until the Covered Person is discharged from Inpatient status.

C. Primary Care Physician.

(1) You must designate a Primary Care Physician for each Covered Person. If you do not select a Primary Care Physician we will assign one.

(2) The Covered Person's Primary Care Physician will be responsible for coordinating Covered Services and making referrals to other Participating Providers. A Covered Person does not need a referral from his/her Primary Care Physician for obstetrical or gynecological treatment from a Participating Provider. A Covered Person may seek care directly from an obstetrician or gynecologist that is a Participating Provider. For all other Providers, the Covered Person must obtain a referral from his/her Primary Care Physician to obtain benefits for Covered Services under this Contract.

(3) You may change the selection of a Primary care Physician no more frequently than once each month. A Covered Person may change his/her Primary Care Physician by submitting a written request, online at [insert website address], or by contacting us at the number shown on your Identification Card. A change in Primary Care Physician selection will be effective no later than thirty (30) days from the date we receive a request.

ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES.

This Article 7 sets forth the procedures for requesting approvals for Covered Services from us as well as general Grievance procedures. In processing claims, we review requests for Precertification, Predetermination, and Post Service Clinical Claims Review to determine whether provided or proposed to be provided Health Care Services are Covered Services. Health Care Services must be Medically Necessary for Health Care Services to be considered Covered Services.

Deleted: the ***claim review procedures for benefit determinations adverse to the Covered Person***.

A. Covered Service Review Requests

(1) Types of Covered Service Review Requests.

(a) Precertification – 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.

(b) Predetermination – An optional, voluntary prior or concurrent request for a benefit coverage determination for a Health Care Service. We will review this Contract to determine if there is an Exclusion for the service or treatment requested. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service or treatment meets our definition of Medical Necessity, or if it is Experimental/Investigative as that term is defined in this Contract.

(c) Post Service Clinical Claims Review – A retrospective review (Post-Service) for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Precertification and did not undergo a Predetermination review. Post Service Clinical Claims Reviews are done for Health Care Services for which we have a related clinical coverage guideline and are typically initiated by us.

(2) Most Participating Providers know which Health Care Services require Precertification and will get Precertification or ask for Predetermination from us as needed. The Covered Person's Primary Care Physician and all other Participating Providers have received information from us on the procedures for requesting approvals for Covered Services and are responsible for meeting the requirements under such procedures. Generally, the Participating Provider ordering the service, treatment or admission will contact us to ask for Precertification or Predetermination reviews ("Requesting Provider"). We will work directly with the Requesting Provider regarding such review requests; however, the Covered Person's Designated Representative may act on the Covered Person's behalf throughout the review process.

(3) We will utilize our clinical coverage guidelines, including internally developed guidelines, procedures, and preventative care clinical coverage guidelines, to help us determine whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions Identified

as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

(4) The Covered Person is entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact us at [toll free number].

B. Review Request Categories.

(1) Urgent Care – A request for Precertification or Predetermination that in the view of the attending Provider, or any physician with knowledge of the Covered Person's medical condition, could seriously jeopardize the Covered Person's life or health or the Covered Person's ability to regain maximum function, or would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Urgent Care Claim.

(2) Pre-Service – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

(3) Concurrent Care – A request for Precertification or Predetermination that is conducted during an ongoing course of treatment or admission. If we have approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by us of such course of treatment before the end of such period of time or number of treatments shall constitute a benefit determination adverse to the Covered Person. We will notify the Covered Person sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination before the benefit is reduced or terminated.

(4) Post-Service – A request for approval that is made after the service, treatment or admission has occurred. Post-Service review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

C. Benefit Decision and Notice Requirements.

(1) We will resolve benefit review requests according to the timeframes listed in the table below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws.

Request Categories	**Timeframe Requirement for Benefit Decisions and Notification**
Pre-Service Claim	15 calendar days from receipt of request
Pre-Service Urgent Care Claim	72 hours from receipt of request

Concurrent Care Claim	15 calendar days from receipt of request
Concurrent Urgent Care Claim	24 hours from receipt of request
Post-Service Claim	20 business days from receipt of request

D. Timeframe Extensions for Benefit Decisions and Notifications.

(1) Post-Service and Pre-Service Claims. If we are unable to complete our review due to circumstances beyond our control, we will notify the Covered Person, the Covered Person's Designated Representative, and the Requesting Provider in writing within:

(a) Fourteen (14) days after our receipt of a Pre-Service claim review request, and

(b) Nineteen (19) days after our receipt of a Post-Service claim review request.

The written notice will include the reason for the delay, a list of any applicable additional information that we need from the Covered Person in order to complete our review and a revised timeframe for the resolution. If the reason for the delay is because the Covered Person's review request lacked sufficient information to complete our review of the Covered Person's request, the Covered Person, the Covered Person's Designated Representative and Requesting Provider will have forty-five (45) days from receiving our notice of delay to provide the necessary information. We will notify the Covered Person, the Covered Person's Designated Representative and the Requesting Provider of our decision within not more than ten (10) days after notifying the Covered Person, the Covered Person's Designated Representative and Requesting Provider of the reason for our delay or of our receipt of the necessary information or of the end of the period afforded to the Covered Person to supply the necessary information, as applicable. If we do not get the specific information we need or if the information is not complete by the timeframe provided to the Covered Person, we will make a decision based upon the information we have.

(2) Urgent Care Claims. If the Covered Person fails to provide us with sufficient information to review the Covered Person's Urgent Care Claim review request, we will notify the Covered Person as soon as possible, but not later than twenty-four (24) hours after our receipt of the claim, of the specific information necessary to complete our review. The Covered Person will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. We will notify the Covered Person, the Covered Person's Designated Representative and Requesting Provider of our decision as soon as possible, but in no case later than forty-eight (48) hours of the earlier of the following:

(a) our receipt of the necessary information, or

(b) the end of the period afforded to the Covered Person to supply the necessary information.

If we do not get the specific information we need or if the information is not complete by the timeframe provided to the Covered Person, we will make a decision based upon the information we have.

E. Denial of Experimental Treatment.

(1) If we deny coverage for a treatment, procedure, drug or device on the grounds that the treatment, procedure, drug or device is experimental, we will provide the Covered Person with a written explanation that includes the following information:

(a) The basis for the denial.

(b) The Covered Person's right to Appeal our decision.

(c) Our telephone number that the Covered Person may contact for assistance in initiating an Appeal of our decision.

(2) If the Covered Person's health situation is life threatening or is an emergency, the Covered Person is entitled to a review of our decision to deny coverage on the grounds that the treatment, procedure, drug or device is experimental that takes not more than seventy-two (72) hours.

F. What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(1) Availability, delivery, appropriateness, or quality of health care services.

(2) Handling or payment of claims for health care services.

(3) Matters pertaining to the contractual relationship between you and us.

G. Who May File.

(1) You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

(2) If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

H. How a Grievance May Be Filed.

(1) You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, including fax]

(2) A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

I. No Retaliation. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 7.

J. Grievance Procedure.

(1) Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

(2) Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

(3) Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

(4) Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

(5) Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

K. Appeals Procedure.

(1) Right to an Appeal.

(a) If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

(b) You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

(c) The Appeal may be expressed orally or in writing by contacting us at the address and phone number provided below.

[Address]

(d) We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

(2) Appeal Panel.

(a) We will appoint a panel of qualified individuals to resolve your Appeal (the "Appeal Panel"). The Appeal Panel will resolve your Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

(b) The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date and place during normal business hours for the Appeal Panel to meet to discuss your Appeal. You will be given seventy-two (72) hours advance notice of the date and time of the meeting.

(c) You or Your Designated Representative may:

(a) appear in person before the Appeal Panel; or

(b) communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

(d) You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

(e) To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

(f) The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

(g) If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:

(a) Has knowledge in the medical condition and Health Care Service;

(b) Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and

(c) Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with you or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.

(3) Appeal Decision and Notice of Decision.

(a) The Appeal Panel's decision regarding your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

(b) The Appeal Panel will resolve Appeals according to the timeframes listed in the table below.

Appeal Categories	**Timeframe Requirement for Appeal Decisions and Notification**
Appeal of a Pre-Service Claim Decision	30 calendar days from our receipt of the Appeal
Appeal of a Pre-Service Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Concurrent Care Claim Decision	15 calendar days from our receipt of the Appeal
Appeal of a Concurrent Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Post-Service Claim Decision	45 calendar days from our receipt of the Appeal

(c) We shall notify the Covered Person or the Covered Person's Designated Representative of our decision in writing regarding the Appeal within five (5) business days after we complete our investigation.

(4) Expedited Review of Internal Appeals.

(a) An Expedited Review of an internal Appeal may be initiated orally, in writing or by other reasonable means available to the Covered Person, the Covered Person's Designated Representative or the Covered Person's Provider.

(b) Expedited Review is available only if the Covered Person's attending Provider believes that, based upon the Covered Person's medical condition, our standard internal Appeal procedure could seriously jeopardize the Covered Person's life or health or the Covered Person's ability to regain maximum function, or could subject the Covered Person to severe pain that cannot be adequately managed.

(c) Appeals of Urgent Care Claim decisions are referred directly to our Expedited Review procedure for investigation and resolution.

Deleted: <#>Benefit Decision Appeals¶
<#>Right to Appeal. If the Covered Person or the Covered Person's Requesting Provider disagrees with our decision regarding the Covered Person's benefit review request the Covered Person or the Covered Person's Designated Representative may initiate an Appeal by contacting us either in writing and/or by phone at the address and phone number provided below.¶
[Address]¶
The Covered Person's Appeal must be initiated within 180 days of receiving our decision regarding the Covered Person's benefit review request. We will acknowledge your Appeal within 3 business days of our receipt of the Appeal Request. ¶
<#>Appeal Panel. We will appoint a panel of qualified individuals to resolve the Appeal (the "Appeal Panel"). We will ensure that no individual is appointed to the Appeal Panel who was involved in the matter giving rise to the compliant or in the initial investigation of the complaint. ¶
<#>If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:¶
<#>Has knowledge in the medical condition and Health Care Service;¶
<#>Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and¶
<#>Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with the Covered Person or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.¶
<#>The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date and place during normal business hours for the Appeal Panel to meet to discuss the Appeal. The Covered Person will be given seventy-two (72) hours advance notice of the date and time of the meeting. The Covered Person or the Covered Person's Designated Representative may appear in person at the Appeal Panel meeting or communicate with the Appeal Panel through appropriate other means if the Covered Person or the Covered Person's Designated Representative are unable to appear in person. ¶
Timeframe for Resolution of Appeals.

(d) We will complete our Expedited Review of the Appeal as soon as possible given the medical exigencies but no later than within 72 hours after our receipt of the Covered Person request for Appeal.

(e) We will communicate our decision regarding the Appeal by telephone to the Covered Person, the Covered Person's Designated Representative, and the Covered Person's attending Provider. We will also provide written notice of our decision to the Covered Person, the Covered Person's Designated Representative and the Covered Person's attending Provider.

(f) An Expedited Review of Concurrent Urgent Care Claims and Pre-Service Urgent Care Claims may occur at the same time as an External Review (as described below).

L. External Review

(1) The Covered Person or the Covered Person's Designated Representative may seek External Review if our decision regarding the Appeal upheld a decision that was adverse to you regarding any of the following.

(a) A Medically Necessary service.

(b) A utilization review decision.

(c) A determination that a proposed service is Experimental/Investigational.

(d) A decision to rescind the Covered Person's Contract.

If the Covered Person's Appeal did not involve one of the above adverse decisions, the Covered Person is not entitled to an External Review.

(2) If the Covered Person has the right to an External Review under Medicare (42 U.S.C. 1395, et seq.) the Covered Person may not request an External Review of our Appeals decision under the procedures outlined in this Contract.

(3) If the Covered Person's situation qualifies, the Covered Person or the Covered Person's Designated Representative must file a written request for an External Review with us within 120 days after the Covered Person receives notice of our internal response to the Appeal.

(4) Independent Review Organization (IRO).

(a) If an External Review is requested, we will forward all information related to the Covered Person's External Review to an IRO selected from the list of IROs that are certified by the Indiana Department of Insurance.

(b) The IRO will make a determination to uphold or reverse our Appeal decision within seventy-two (72) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or

within fifteen (15) business days if the condition does not involve an Urgent Care Claim.

(c) The IRO will notify the Covered Person and the Covered Person's Designated Representative of its decision within twenty-four (24) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within seventy-two (72) hours if the review does not involve an Urgent Care Claim.

(d) If the IRO decision reverses our Appeals decision, we will notify the Covered Person, the Covered Person's Designated Representative or Provider in writing of the steps we will take to comply with the Iron's decision.

M. Important Contact Information and Notice to Covered Persons

(1) Questions regarding the Covered Person's coverage should be directed to: Indiana University Health Plans; [toll free number]

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(2) If the Covered Person (a) needs the assistance of the governmental agency that regulates insurance; or (b) has a complaint the Covered Person has been unable to resolve with us the Covered Person may contact the Department of Insurance by mail, telephone or email:

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

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

Complaints can also be filed electronically at www.in.gov/idoi.

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(3) The review procedures described in this Article 7 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

ARTICLE 8. PAYMENT FOR COVERED SERVICES

A. How to Obtain Benefits.

(1) Whenever the Covered Person receives Health Care Services, the Covered Person must provide the Provider with a copy of the Covered Person's Identification Card.

(2) When the Covered Person receives Covered Services from a Participating Provider you are not required to file a claim. Since no claim filing is required, you are not required to follow the procedures outlined in Section C of this Article 8.

B. Who Receives Payment Under This Contract.

(1) We pay Benefits for the Covered Person's Covered Services directly to a Participating Provider.

(2) If the Covered Person receives Covered Services from a Non-Participating Provider as provided in Article 6 Section B, we will pay Benefits to the Non-Participating Provider, unless you agreed to make payment to the Non-Participating Provider and are entitled to reimbursement for such payment.

C. Payment for Covered Services received from Non-Participating Providers.

(1) Time to File Claims. For Covered Services received from a Non-Participating Provider, written notice of a claim must be given to us, by you or the Non-Participating Provider, within thirty (30) days of the date the Covered Services began. Failure to furnish the claim within thirty (30) days will not invalidate or reduce any claim if submission within thirty (30) days was not reasonably possible, so long as the claim is submitted within a reasonable time.

(2) Claim Forms. We shall provide forms to you for filing Proof of Loss within fifteen (15) days of notice of any claim. If you do not receive the forms within fifteen (15) days, written notice of services rendered may be submitted to us without the claim form. Claim forms are available on our website at [website address].

(3) Proof of Loss. Proof of loss under this Contract must be furnished to us within ninety (90) days after the loss. Failure to furnish the claim within ninety (90) days will not invalidate or reduce any claim if submission within ninety (90) days after the loss was not reasonably possible, so long as the claim is submitted within one (1) year after the time required under this Contract unless you were legally incapacitated.

(4) Address. All correspondence regarding claims should be sent to us at:

Indiana University Health Plans
[Address]
[City/state/zip]
[Fax]

Deleted: [
Deleted:]

(5) Amount of Payment. Payment for Health Care Services received from a Non-Participating Provider will be the lesser of the following amounts.

(a) The usual, customary and reasonable charge for the Health Care Service;

(b) An amount agreed upon by us and the Non-Participating Provider.

D. Clean Claims.

(1) A clean claim is a claim submitted by a Provider for payment that has no defect. We shall pay or deny each clean claim as follows.

(a) If the claim is filed electronically, within thirty (30) days after the date we receive the claim.

(b) If the claim is filed on paper, within forty-five (45) days after the date we receive the claim.

(2) If we fail to pay or deny a clean claim in the time frames set forth above and subsequently pay the claim, we will pay the Provider that submitted the claim allowable interest in accordance with Indiana Code § 27-8-5.7-6.

ARTICLE 9. COORDINATION OF BENEFITS

This Article applies only if you also have other health benefits coverage with another Plan. The Definitions contained in this Article apply throughout this Article 9 but do not apply to the rest of the Contract.

A. **When you have other health benefits**. In the event that you are covered by two health insurance contracts, plans or policies ("Plans") providing similar benefits and you receive a Health Care Service that would be covered by both Plans, we will coordinate benefit payments with any payment made under the other Plan. One company will pay its full benefit as the Primary Plan. The other company will pay Secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments.

B. **Definitions**.

(1) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the Plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(2) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

(3) "Closed Panel Plan" means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in the case of emergency or referral by a panel Covered Person.

(4) "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(5) "Plan" means any of the following that provides benefits or services for medical treatment:

(a) Any group or blanket insurance contract, plan or contract, except that blanket school accident coverage or such coverage offered to

substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or contract.

(b) Any self-insured or noninsured Plan or any other Plan arranged through an employer, trustee, union, employer organization or employee benefit organization.

(c) Any coverage under governmental programs or any coverage required to be provided by any statute. However, Medicaid and any Plan whose benefits are, by law, excess to those of any private insurance plan or other nongovernmental plan shall not be considered health insurance policies.

(d) Group or nongroup coverage through Closed Panel Plans or group type contracts.

(e) Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional "fault" type contracts.

(6) "Primary" or "Primary Plan" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If the Plan is Primary to another Plan, the Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(7) "Secondary" or "Secondary Plan" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If the Plan is Secondary to another Plan, the Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

C. **Rules To Determine Payment**. When two or more Plans pay benefits, the rules for determining the order of payments are as follows:

(1) The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

(2) If the other Plan does not have a provision similar to this one, then it will be primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(3) A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. **Order of Determination of Benefits Rules**: The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent is Primary, for example as an employee, subscriber or retiree is

primary and the Plan that covers the person as a Dependent is Secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent; then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, subscriber or retiree is Secondary and the other Plan is Primary.

(2) Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods commencing after the Plan is given notice of the court decree.

(d) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(a) The Plan of the Custodial Parent.

(b) The Plan of the spouse of the Custodial Parent.

(c) The Plan of the non-Custodial Parent.

(d) The Plan of the spouse of the non-Custodial Parent.

(3) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is Primary. The same would hold true is a person is a Dependent of a person covered as a retiree or an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined Section (C)(1) of this Article 9.

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, subscriber or retiree (or as that person's Dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, subscriber or retiree longer is Primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid if it had been Primary.

E. Payment of the Benefit When This Plan is Secondary.

(1) When this Plan is Secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other Plan and this Plan do not exceed your expenses for an item of service. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by the Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

(a) Determine its obligation to pay or provide benefits under its Plan;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

(2) If there is a benefit reserve, the Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

(3) If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, Coordination of Benefits shall not apply between that Plan and other Closed Panel Plans.

F. Payments to others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid.

G. Our Right to Recover Overpayment. In some cases, we may have made payment even though you had coverage under another Plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the

payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other Plan. You agree to sign any document that we deem necessary to help us recover any overpayment.

ARTICLE 10. TERMINATION OF COVERAGE

A. [**Guaranteed Renewable.** As long as a Covered Person continues to be a Qualified Individual and this Contract continues to be a Qualified Health Plan, you may renew this Contract at your option without regard to the health status of you or any Covered Person.]

[Guaranteed Renewable. Coverage under this Contract is guaranteed renewable at the discretion of the Subscriber, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, as described in this Article 10. The Subscriber may renew this Contract at the Subscriber's option without regard to the health status of you or any Covered Person. You may renew this Contract by payment of the renewal premium by the end of the Grace Period of the premium due date, provided the following requirements are satisfied:

(1) Eligibility criteria outlined in Article 2 continues to be met.

(2) There are no fraudulent or intentional misrepresentations on the application or under the terms of this Contract.

(3) Coverage has not been terminated by us under the terms of this Contract.]

B. **Termination.** We may terminate this Contract or coverage of a Covered Person for the following reasons.

(1) The Covered Person is no longer eligible for coverage [through the Indiana Marketplace].

(2) A Covered Person is no longer eligible under [the rules of the Indiana Marketplace or] the terms of this Contract.

(3) You do not pay premium and the applicable Grace Period has been exhausted.

(4) We receive a request from you to terminate the Contract.

(5) You or a Covered Person commits an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact.

(6) A Covered Person changes coverage to another [Qualified Health Plan] [health plan] during the [Indiana Marketplace] Open Enrollment Period or a Special Enrollment Period.

(7) [The Contract is no longer a Qualified Health Plan or we are decertified by the Indiana Marketplace.]

(8) You no longer reside in our Service Area.

(9) We discontinue a particular product provided that we provide you with written notice at least ninety (90) days before the date the product will be discontinued, we offer you the option to purchase any other individual contract we currently offer, and we act uniformly without regard to any health status-related factor.

(10) We discontinue all contracts in the individual market in Indiana provided that we provide you and the Indiana Department of Insurance with written notice at least 180 days before the date of the discontinuance, we discontinue and do not renew all contracts in the individual market in the State of Indiana, and we act uniformly without regard to any health status-related factor.

(11) We may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with the laws of the State of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

C. Effective Date of Termination. [Termination of this Contract automatically terminates all coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if this Contract is in effect at the time such services are provided.]

(1) If you terminate this Contract or coverage for a Covered Person, the last day of coverage [will be on the last day of the billing period for which premium has been paid. A request for termination must be received by us in writing] [is:

(a) The termination date specified by you, if reasonable notice is provided;

(b) If you do not provide reasonable notice, fourteen (14) days after the termination is requested, or

(c) If you do not provide reasonable notice and request a termination date in less than fourteen (14) days, on a date determined by us if we are able to implement termination in fewer than fourteen (14) days.]

(2) [If newly eligible for Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.]

(3) [If all Covered Persons are no longer eligible for coverage through the Indiana Marketplace, the last day of coverage is the last day of the month following the date notice is sent to us by the Indiana Marketplace, unless you request an earlier termination effective date.] [If you move outside of the Service Area, the last day of coverage for you and all of your Dependents will be at the end of the billing period that contains the date you no longer resided in the Service Area.]

(4) [If a Covered Person is no longer eligible for coverage under the rules of the Indiana Marketplace or the terms of this Contact, the last day of coverage is the last day of the month following the date the Covered Person loses eligibility.] [If a Dependent no longer meets the definition of Dependent, the last day of coverage for the Dependent will be on the last day of the billing period in which we received notice of the Dependents loss of eligibility.]

(5) In the case of a termination for non-payment of premium and the applicable Grace Period has been exhausted, the last day of coverage [for all Covered

Persons] will [be either the last day of the first month of the 3-month Grace Period or] the last day for which premium was paid.

(6) [In the case of a termination due to a change to another Qualified Health Plan, the last day of coverage is the day before the effective date of coverage in his or her new Qualified Health Plan.]

D. Notice of Termination.

(1) We shall provide you with written notice of our intent to terminate or not renew this Contract at least sixty (60) days prior to the effective date of the termination. This notice will identify the date upon which your coverage will terminate.

(2) Our notice to the Subscriber shall be deemed as notice to all Covered Persons and is sufficient if mailed to the Subscriber's address as it appears in our records.

(3) Termination of this Contract shall not prejudice any claim for Covered Services rendered before the effective date of the termination.

E. Continuation of Coverage.

(1) If we terminate this Contract, except for a termination due to our receivership, and a Covered Person is hospitalized for a medical or surgical condition on the effective date of the termination, coverage will continue for Inpatient Covered Services. Benefits shall end on the earliest of the following dates.

(a) The date the Covered Person is discharged from the Hospital.

(b) The date the Covered Person is covered under other health coverage if that coverage covers the Inpatient Hospital services.

(c) Sixty (60) days after the date this Contract ends.

(d) The last day the required premium has been paid if the Grace Period expires and the Subscriber has not made the required payment.

(e) The date the you terminate coverage.

(2) If this Contract terminates due to our receivership, coverage will continue for the following time period:

(a) The duration of the contract period for which premiums have been paid.

(b) If a Covered Person is hospitalized on the date of our receivership for the longer of the following time periods.

(A) The period ending when the Covered Person is discharged from the Inpatient hospitalization.

(B) The duration of the contract period for which premiums have been paid.

F. **Rescission.** If within two (2) years after the Effective Date of this Contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that the Subscriber or a Covered Person did not disclose on the application, we may rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding your newly born children within 31 days of birth), we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that the Subscriber or a Covered Person did not disclose on the application, we may rescind coverage for the additional Dependent as of his or her original Effective Date. Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by the Subscriber or a Covered Person may result in termination or rescission of coverage. The Subscriber is responsible to pay us for the cost of previously received services based on the Allowed Amount for such services, less any Copayments/Coinsurance paid or Premium paid for such services.

This Contract may also be terminated if the Subscriber or a Covered Person knowingly participates in or permit fraud of deception by any Provider, vendor or any other person associated with this Contract. Termination for any act, practice or omission that constituted fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give the Subscriber at least thirty (30) days written notice prior to the rescission of this Contract.

G. **Reinstatement.** If this Contract was terminated for non-payment of premium, you may request reinstatement of the Contract from [the Indiana Marketplace] [us] within 30 days of the effective date of the termination. You must remit all premium that was due for the coverage upon reinstatement. Upon [notice from the Indiana Marketplace and] receipt of the outstanding premium, we will reinstate coverage as of the effective date of the termination.

H. [**Certification of Prior Creditable Coverage If Required by Law.** If this coverage is terminated, all Covered Persons will receive certification from us showing that they were covered under this Contract. A Covered Person may need this certification document in order to purchase other health coverage. Certifications may be requested within twenty-four (24) months of losing coverage.

A Covered Person may also request certification be provided to he or she at any other time, even if he or she has not lost your coverage under this Contract. If a Covered Person has any other questions regarding certification of creditable coverage, contact the Customer Service telephone number on the back of your Identification Card.]

ARTICLE 11. GENERAL PROVISIONS

A. **Entire Contract**. This Contract, the Schedule of Benefits, and any application, rider or amendment(s) make up the entire agreement between you and us as of the Effective Date and supersede all other agreements. All statements made by you shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce coverage under this Contract or be used in defense of a legal action unless it is contained in the application.

B. **No Assignment**. The benefits provided under this Contract are for the personal benefit of all Covered Persons. You may not assign any of these rights to coverage. Any attempt by you to assign this Contract to any third party is void. Provided, however, that subject to our right to disapprove, you may assign your right to reimbursement for Covered Services to the Provider who provided such Covered Services.

C. **Notice**. Any notice that we give to you under this Contract will be mailed to your address as it appears on our records. Our notice to the Subscriber is deemed notice to all. Notice is deemed delivered three (3) calendar days after its deposit in the United State Mail with first class postage prepaid unless otherwise stated in this Contract. If you have to give us any notice, it should be mailed to:

Indiana University Health Plans, Inc.
950 North Meridian Street, Suite 200
Indianapolis, Indiana 46204

D. **Relationship Between Parties**. The relationships between us and Participating Providers are *solely* contractual relationships between a payor and independent contractors. Non-Participating Providers have no contractual relationship with us, nor are they our independent contractors. Providers are not our agents or employees. We and our employees are not employees or agents of Providers. The relationship between a Provider and any Covered Person is that of Provider and patient. The Provider is *solely* responsible for the services provided to any Covered Person.

E. **Disagreement with Recommended Treatment.** Each Covered Person enrolls in this Contract with the understanding that the Provider is responsible for determining the treatment appropriate for their care. The Covered Person may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate Health Care Services in a manner compatible with the Covered Person's wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice. If the Covered Person refuses to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, the Covered Person will be so advised. In such case, the Provider and we, as applicable, may determine that neither this Contract nor the Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of this Contract for the condition under treatment or any complications thereof.

Deleted: <#>GRIEVANCE PROCEDURES ¶
The Grievance procedures provided in this Article 11 are established and maintained by us for the filing, investigating, and resolving of Grievances and Appeals that are ***unrelated to benefit decisions*** that are adverse to you. ***For procedures applicable to benefit decisions please refer to Article 7 of this Contract.***¶
What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.¶
<#>Availability, delivery, appropriateness, or quality of health care services.¶
<#>Handling or payment of claims for health care services.¶
<#>Matters pertaining to the contractual relationship between you and us.¶
<#>Who May File. ¶
<#>You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure. ¶
<#>If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.¶
<#>**How a Grievance May Be Filed. ¶**
<#>You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.¶
[Address, including fax] ¶
<#>A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing. ¶
No Retaliation. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 10 or Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 10 or Article 7.¶
<#>**Grievance Procedure**. ¶
<#>Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken. ¶
<#>Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.¶
<#>Decision. Our decision regarding your Grievance must be made as soon as pos ... [1]

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F. **Your Medical Records**. As a condition precedent to the approval of claims hereunder, each Covered Person authorizes and directs any Provider that furnishes benefits hereunder to make available to us information relating to all Health Care Services, copies thereof and other records as needed by us for purposes of administering this Contract. In every case we will hold such information and records as confidential in accordance with state and federal confidentiality requirements.

G. **Second Opinion Policy**. A second opinion may be required at our discretion prior to the scheduling of certain Covered Services. We will advise you if a proposed Covered Service is subject to the second opinion policy. If so, you must consult with a second Participating Provider prior to the scheduling of the service. You must (a) contact us to obtain a list of Participating Providers who are authorized to render a second opinion, and (b) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider. You must obtain the second opinion within thirty-one (31) days of the first opinion or as soon thereafter as is reasonably possible. Second opinions we have arranged as described above are provided at no cost to you. A second opinion may also be obtained at the request of a Covered Person, subject to separate benefit restrictions and/or Copayments or Coinsurance described in this Contract.

H. **Who May Change This Contract**. This Contract may not be modified, amended or changed, except in writing, and signed by one of our officers. No employee, agent or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage or the conditions of eligibility, enrollment or participation unless in writing and signed by one of our officers. We are not bound by any verbal statements. We will provide the Subscriber with written notice of any material modification to this Contract not later than sixty (60) days prior to the date on which such material modification will become effective.

I. **Renewal Date**. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date for the term set forth in the Contract unless otherwise terminated by us as permitted by the Contract or by you upon thirty (30) days' prior written notice.

J. **Identification Cards**. Identification Cards are issued by us for identification only. Possession of any Identification Card confers no right to services or benefits under this Contract. To be entitled to such services or benefits the Covered Person's premiums must be paid in full at the time the Health Care Services are sought to be received. Coverage under this Contract may be terminated by us if the Covered Person allows another person to wrongfully use the Identification Cards.

K. **Right to Develop Guidelines and Administrative Rules**. We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Contract. An example of the use of the standards is to determine whether care was Medically Necessary. These standards will not be contrary to the descriptions in this Contract. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Contract.

L. **Non-Discrimination**. In compliance with state and federal law, we shall not discriminate on the basis of age; gender; color; race; disability; marital status; sexual preference; religious affiliation; or public assistance status. We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care. We shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew Coverage, (b) cancel coverage, (c) limit Benefits, or (d) charge a different premium. We shall not discriminate against victims of abuse in compliance with Indiana Code Sec. 27-8-24.3-1.

M. **Incontestability**. The validity of the Contract may not be contested after two (2) years, except for nonpayment of premiums or if the disputed statement is in a written instrument signed by the Subscriber. The ineligibility of Dependent under the Contract may be disputed at any time.

N. **Limitation of Action**. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Contract and within three (3) years from the date the Health Care Services were received.

Deleted: The Subscriber's damages shall be limited to recovery of actual Benefits due under the terms of this Contract. The Covered Person waives any right to recover any additional amounts or damages including, but not limited to, punitive and/or exemplary damages.

O. **Examination of Covered Persons**. We may reasonably require that a Covered Person be examined if a question or dispute about the provision of or payment for Covered Services arises. The exam will be performed by a Participating Provider acceptable to us. We will pay for the exam.

P. **Right of Recovery.** If we pay for Health Care Services that, according to the terms of the Contract, should not have been paid, we reserve the right to recover such amounts from whom they have been paid (including the Covered Person or Provider) or any other appropriate party.

Q. **Contract is not a Medicare supplement policy**. Any Covered Services that are covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled. The benefits under this Contract for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be Primary. Where Medicare is Primary, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

R. **Contract is Not Worker's Compensation Insurance**. The coverage provided under this Contract does not replace, supplement or provide a substitute for benefits to which a Covered Person is entitled under worker's compensation, occupational disease, and similar laws. The Contract does not cover Health Care Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's

compensation, occupational disease and similar laws, even when the circumstances below are present.

(1) If the Covered Person's employer is not properly insured or self-insured under such laws.

(2) When a Covered Person refuses to use his or her employer's designated Provider.

(3) When a Covered Person has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

A Covered Person must contact his employer or its worker's compensation or occupational disease insurer for the provision or payment of such Health Care Services.

S. **General Conditions for Benefits**. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within our control we will pay benefits for Covered Services as provided in this Contract to the extent that facilities and personnel are then available, and we shall have no liability or obligation for delay or failure to provide Covered Services due to lack of available facilities or personnel.

T. **Typographical or Administrative Error**. Typographical or administrative errors shall not deprive a Covered Person of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

U. **Conformity with Statutes**. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on the Effective Date shall apply. Any Contract provision which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

V. **Governing Law.** This Contract will be subject to the laws of the state of Indiana.

W. **Severability.** In the event that any provision in the Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

[Schedule of Benefits]

GRIEVANCE PROCEDURES

The Grievance procedures provided in this Article 11 are established and maintained by us for the filing, investigating, and resolving of Grievances and Appeals that are ***unrelated to benefit decisions*** that are adverse to you. ***For procedures applicable to benefit decisions please refer to Article 7 of this Contract.***

What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

Availability, delivery, appropriateness, or quality of health care services.

Handling or payment of claims for health care services.

Matters pertaining to the contractual relationship between you and us.

Who May File.

You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

How a Grievance May Be Filed.

You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, including fax]

A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

No Retaliation. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 10 or Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 10 or Article 7.

Grievance Procedure.

Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

Appeals Procedure.

Right to an Appeal.

If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

The Appeal may be expressed orally or in writing.

We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

Appeal Panel.

Our Appeal Panel (the "Appeal Panel") will resolve the Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

You or Your Designated Representative may:

appear in person before the Appeal Panel; or

communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

Appeal Decision and Notice of Decision.

The Appeal Panel's decision regarding Your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

We will notify you in writing of the Appeal Panel's decision within five (5) business days after it is decided.

Notice to Covered Persons.

If you have questions regarding your rights under this Contract or if you need Assistance, please contact us at:

[Indiana University Health Plans]
[toll free number]

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

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

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

Complaints can be filed electronically at www.in.gov/Idoi.

The review procedures described in this Article 11 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

2015 IUHP Indiana Individual On- and Off-Exchange Rate Filing
SERFF Tracking Number: IUHP-129535085
IDOI Objection Letter Date: 05/27/2014
Submitted Date: 05/27/2014 04:37 PM
Response Date: 06/09/2014

General Information: Please note that Indiana University Health Plans, Inc. (IUHP) submitted a rate filing amendment via SERFF on June 4, 2014 which reflected revised assumptions regarding the Medicaid Spend Down population as well as their Sales & Marketing expenses. The page numbers and amounts cited in our responses below refer to the updated Actuarial Memorandum dated May 28, 2014.

1. Please provide the basis for the manual rates mentioned on Page 6.

As noted in Section 6) Credibility Manual Rate Development, on page 5 of the Actuarial Memorandum , the PwC Rating Model used two primary sources of information that served as the basis of our CY2012 manual rates were: 1) Commercial Truven Health MarketScan® Research Databases for U.S. members and providers and 2) OptumInsight (Optum) Comprehensive Pricing Model®. The development of the CY2015 manual rates are summarized below in Exhibit I.

Exhibit I
Indiana University Health Plans, Inc.
Manual Rate Projection and Index Rate Development

CY2012 Base Period Manual Claims		
Base Period Manual Claims (Client-Specific Reimbursement Levels)		$275.77
Normalization Factor (Demographics/Benefit Plan Design)	x	1.1263
Normalized Based Period Manual Claims	=	$310.60
Adjustments		
Benefit Changes	x	1.0192
Morbidity Changes	x	1.0610
Trend Factor	x	1.2388
Medicaid Spend Down	x	1.0520
Pent Up Demand	x	1.0500
Bad Debt	x	1.0050
Adjusted Claim Costs	=	$461.91
Rx Rebates	+	($7.01)
Pediatric Vision	+	$0.24
Projection Period EHB-Only Claim Costs	=	$455.14
Paid To Allowed Ratio	/	67.9%
CY2015 Projected Allowed EHB-Only Claims (Index Rate)	**=**	**$670.70**

Exhibit I - Notes:

- Normalization Factor: The manual data was normalized to reflect changes in age, gender and benefit plan designs from the base period (CY2012) to the projection period (CY2015). The assumed allowed claims cost by age band and gender inherent in the manual rate data sources were applied to both the base and projection period enrollment distributions. This resulted in a demographic adjustment of 1.2429. The manual data was normalized to the assumed average projection period benefit plan design. The PwC Rating Model developed benefit relativities using cost sharing values and expected changes in utilization due to differences in cost sharing. This resulted in an adjustment of 0.9062. The total normalization factor is a product of the demographic and benefit plan adjustments (1.1263 = 1.2429 x 0.9062).

- Benefit Changes: Represents the expected changes in covered benefits due to the Essential Health Benefits (EHB) requirements. Please see Section 6) Credibility Manual Rate Development, page 6 of the Actuarial Memorandum. Since IUHP has a capitated agreement with a third-party partner to provide Pediatric Vision services, the capitation amount was removed from the 2% EHB adjustment noted in the Actuarial Memorandum as follows:

  1.0192 = 1 + [(($310.60 x 2%) - $0.24) / $310.60]

- Morbidity Changes: This adjustment reflects differences in morbidity between the Individual and Group markets, health status of the currently uninsured expected to enroll in 2015, and the impact of transitional ("grandmothered") policies.

- Trend factor: Three years of 7.4% assumed annual trend ($1.2388 = 1.074^3$)

- Medicaid Spend Down: Please see Section 6) Credibility Manual Rate Development, page 6 of the Actuarial Memorandum as well as our response to IDOI Objection Letter Item 2 below.

- Pent Up Demand: Please see Section 6) Credibility Manual Rate Development, pages 6-7 of the Actuarial Memorandum as well as our response to IDOI Objection Letter Item 3 below.

- Bad Debt: Please see Section 6) Credibility Manual Rate Development, page 7 of the Actuarial Memorandum.

2. Also on Page 6, you mention increasing the manual rates due to the Medicaid spend-down, are there any risk adjustment considerations? Also, 15% seems higher than I would expect, do you anticipate any adjustments here?

As noted above, IUHP submitted a rate filing amendment via SERFF on June 4, 2014 which reflected revised assumptions regarding the Medicaid Spend Down population. The 15.0% adjustment has been revised to 5.2%. As indicated in IUHP's SERFF submission, 2015 premium rates have been revised from the May 9th rate filing as follows:

Medicaid Spend Down - using the additional information provided by IDOI on 5/14/2014 ("Masked data_dual_eligible.xls") and 5/20/2014 ("Non-Dual Spenddown - By County.xlsx"), the assumption for this item has been revised based upon IU Health Plans' service area and expected market penetration. This assumption is described in Section 6) Credibility Manual Rate Development, on page 6 of the Actuarial Memorandum.

3. Please provide additional documentation for the 5% increase due to pent up demand. This typically seems to be in the 0 - 2% range.

In addition to the basis outlined in Section 6) Credibility Manual Rate Development, pages 6-7 of the Actuarial Memorandum, the following factors were also considered by IUHP in developing their assumption:

- The Indiana Marketplace enrollment of approximately 132,000 (as of April 19, 2014 per HHS) was less than half of the uninsured population of 276,000 expected to enroll on the Individual exchange per the SOA study performed by Optum/Lewin. It was assumed that most of the enrollment growth in the Indiana Marketplace for 2015 would derive from the remaining uninsured population who did not enroll for coverage in 2014.
- Since IUHP did not offer products on the Individual exchange during 2014, the majority of their 2015 membership was assumed to come from the previously uninsured population rather than retained business. Therefore, the durational impact of the pent up demand would be less prevalent for IUHP than carriers with much higher percentages of retained business.
- IUHP's status as a renowned teaching facility was also assumed to have an impact on pent up demand.

In light of the 0 – 2% range mentioned above as well as the resulting higher hospital and professional charges noted in IDOI Objection Letter Item 16 below, IUHP has revisited this assumption and would like permission to submit a rate filing amendment with a revised pent up demand assumption of 3.0%. IUHP's assumption is slightly higher due to the factors above.

4. From Page 7, can you provide documentation around how the paid to allowed average was determined?

Since IUHP did not have any actual base period experience, the PwC Rating model was used to develop the Paid to Allowed ratios. This model uses actuarially sound principles to evaluate the impact of the cost sharing parameters for each benefit plan.

As noted in Section 8) Paid to Allowed Ratio, on pages 7-8 of the Actuarial Memorandum, the pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT calculates the PMPM costs on both an allowed and paid basis. The "Paid to Allowed Average Factor in Projection Period" shown on Worksheet 1, Section III of the URRT is developed by membership-weighted EHB paid claims divided by membership-weighted EHB allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II. The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

The Paid to Allowed ratios for each plan are shown below in Exhibit II.

Exhibit II
Indiana University Health Plans, Inc.
Paid to Allowed Ratios by Plan

Plan Name	Paid to Allowed Ratio
IU Health Plans Gold Value	0.794
IU Health Plans Silver HSA	0.690
IU Health Plans Silver Value	0.696
IU Health Plans Silver Enhanced	0.702
IU Health Plans Bronze HSA	0.581
IU Health Plans Bronze Value	0.596
IU Health Plans Bronze Enhanced	0.603
Total	0.679

5. How was the $51.43 reinsurance reimbursement determined?

IUHP submitted a rate filing amendment via SERFF on June 4, 2014 wherein the reinsurance reimbursement assumption was revised from ($51.43) to ($46.95) as a result of the changes in the Medicaid Spend Down assumption and Sales & Marketing expenses. Allowed claims (Index rate) were reduced by 7.0% to account for the anticipated 2015 reimbursements from the Federal transitional reinsurance program. This estimate was developed using projected paid claims, a claims probability distribution calibrated to the average expected 2015 claim levels for IUHP, and the federal program guidelines summarized in Section 9) Risk Adjustment and Reinsurance, on page 8 of the Actuarial Memorandum. To estimate the impact of the allowed versus paid basis, the Federal attachment point and maximum coverage limit were increased by the average IUHP out-of-pocket limit. The expected reinsurance reimbursements can be calculated as follows:

($46.95) = (7%) x $670.70

Applying the 2015 transitional reinsurance charge of $3.67 PMPM yields a net reinsurance cost of ($43.28) PMPM.

6. Please split out the intermediate pieces in the 10.5% administrative expenses.

The intermediate pieces of the 10.5% administrative expenses were provided by IUHP and are shown below in Exhibit III.

Exhibit III
Indiana University Health Plans, Inc.
Administrative Services Breakdown

Billing and Collections	0.7%
BPO (Claims Processing) and IT	2.8%
Finance	0.9%
PBM	1.8%
Customer Service	1.3%
Medical Management	0.6%
Provider Contracting	0.6%
Facility (Overhead) and Other	0.6%
Legal and Compliance	0.4%
Other Operations	0.3%
Underwriting and Actuarial	0.6%
Total Administrative Expenses	10.5%*

* differences due to rounding

7. What are the pieces in the 3.7% sales and marketing expense?

As noted above, IUHP submitted a rate filing amendment via SERFF on June 4, 2014 which reflected revised assumptions regarding their Sales & Marketing expenses. As indicated in IUHP's SERFF submission, 2015 premium rates have been revised from the May 9th rate filing as follows:

Sales & Marketing Expenses - following submission of the original rate filing on May 9th, IUHP has obtained additional information regarding the prevailing broker commission rates in the Indiana Individual market. As such, the rates have been revised with reduced Sales & Marketing expenses, reflecting IUHP's expected commission rates as well as the assumed distribution of brokered vs. non-brokered membership. The revised assumption is provided in Section 10) Non-Benefit Expenses and Profit & Risk, on pages 8-9 of the Actuarial Memorandum.

The table below summarizes the development of the revised Sales & Marketing expenses.

(a)	% of IUHP Individual Business Sold On-Exchange	90%
(b)	% of IUHP Individual Business Sold Off-Exchange	10%
(c)	% of On-Exchange Business Subject to Commissions	25%
(d)	Broker Commission Rates in Indiana Individual Market	$19.00 PMPM
(e)	Overall Commission Assumption (e) = (a) x (c) x (d) + (b) x (d)	$6.18 PMPM

8. Please provide information as to why IUHP is not subject to the ACA issuer fee.

This assumption was predicated on the information available at the time of our May 9th initial rate filing. At that time, it was anticipated that IUHP's Medicare Advantage business would be migrated to a separate non-profit entity in 2014. Upon completion of that migration process, the remaining non-Medicare written premium for IUHP would be less than the $25 million threshold for both 2014 and 2015, and therefore the ACA issuer fee would not apply.

However, subsequent to the May 9th rate filing, IUHP has indicated that the current Medicare Advantage business would not be migrated to the new non-profit entity during 2014. IUHP now anticipates that their book of business (including the new Individual On- and Off-Exchange HMO product) will be subject to the ACA issuer fee. As a result, IUHP would like to request permission to submit a rate filing amendment to include an assumption of 2.0% in the 2015 individual rates for the ACA issuer fee.

9. It appears you are starting with 2012 allowed costs to get the index rate. Please provide the intermediate steps used to get to the $734.69 Index Rate in the URRT.

IUHP submitted a rate filing amendment via SERFF on June 4, 2014 wherein the Index Rate in the URRT was revised from $734.69 to $670.70 as a result of changes in the Medicaid Spend Down assumption and Sales & Marketing expenses.

Please refer to Exhibit I included in our response to IDOI Objection Letter Item 1 above.

10. Why is the exchange user fee not 3.5%?

As indicated in our response to IDOI Objection Letter Item 7 above, as well as in Section 10) Non-Benefit Expenses and Profit & Risk – Taxes and Fees, on page 9 of the Actuarial Memorandum, IUHP's rate filing submission encompasses both On and Off Exchange Individual products. IUHP expects 90% of their 2015 Individual business will be sold through the Indiana Marketplace.

Since the exchange user fee only applies to the portion of business sold On Exchange, the exchange user fee was calculated as follows:

(a)	Initial Exchange User Fee	3.50%
(b)	% of IUHP Individual Business Sold On Exchange	90%
(c)	Final Exchange User Fee (c) = (a) x (b)	3.15%

11. Please step me through the adjustments in getting from the Plan Adjusted Index Rate to the Market Adjusted Index Rate with documentation for the pieces.

Please refer to Appendix D of the Actuarial Memorandum. If additional information is required, please let us know.

12. Where is the calculation for the tobacco surcharge done?

The tobacco surcharge impact was developed as follows:

a. Calculated the weighted average tobacco surcharge of 1.205 by applying the membership distribution by age (please see Appendix B) to age-based tobacco factors (please see Appendix C)
b. Based on our assessment of the Individual market, we believe that 5-10% of enrollees will self-report as tobacco users. IUHP selected 7% as their assumption.
c. The calculation of the final tobacco surcharge of 1.014 is shown below.

(a)	Surcharge for Tobacco Users	1.205
(b)	Surcharge for Non-Tobacco Users	1.000
(c)	% Tobacco Users	7%
(d)	% Non-Tobacco Users	93%
(e)	Final Tobacco Surcharge (e) = (a) x (c) + (b) x (d)	1.014

13. Please provide a numeric impact that the Cost Sharing Adjustment has on the Plan Adjusted Index Rate.

A sample calculation for the IU Health Plans Gold Value plan is shown below in Exhibit IV. The crosswalk shows the steps from the Index Rate to the Market Adjusted Index Rate, and then to the Plan Adjusted Index Rate.

Exhibit IV
Indiana University Health Plans, Inc.
Plan Adjusted Index Rate Development
Sample Calculation - IU Health Plans Gold Value

Market-Wide Adjustments		
Index Rate		$670.70
Net Reinsurance Reimbursement	+	($43.28)
Exchange User Adjustment Fee	+	$16.06
Market Adjusted Index Rate		$643.47
Plan-Specific Adjustments		
Adjustment for Induced Utilization	+	$31.24
Smoker Adjustment	-	$9.12
Cost Sharing	-	$142.82
Fixed Costs	+	$6.42
Variable Costs	+	$92.01
Plan Adjusted Index Rate		$621.20

The value of ($120.70) found in column (b) of Appendix D was calculated as $31.24 - $9.12 - $142.82.

The value of $98.43 found in column (c) of Appendix D was calculated as $6.42 + $92.01.

Exhibit IV - Notes:

- Rounding: There may be small differences in the values presented due to rounding.
- Index Rate: Please see response to IDOI Objection Letter Item 1 above.
- Net Reinsurance Reimbursement: Please see response to IDOI Objection Letter Item 5 above.
- Exchange User Adjustment Fee: This fee is developed by applying the assumed Exchange User Fee (please see response to IDOI Objection Letter Item 10 above) to the Single Risk Pool Gross Premium Average Rate PMPM (shown on Worksheet 1 of the URRT), and is calculated as follows:

(a)	Exchange User Fee	3.15%
(b)	Single Risk Pool Gross Premium Average Rate PMPM	$509.79
(c)	Exchange User Fee PMPM (c) = (a) x (b)	$16.06

- Adjustment for Induced Utilization: As noted in Section 15) Plan Adjusted Index Rates – Actuarial Value and Cost Sharing Adjustment, on pages 11-12 of the Actuarial Memorandum, the Market Adjusted Index Rate was adjusted for the plan-specific Induced Utilization factor. The

induced utilization load for the Gold Value plan was 0.0485. The adjustment is calculated as follows:

(a)	Market Adjusted Index Rate	$643.47
(b)	Induced Utilization Load	0.0485
(c)	Induced Utilization Adjustment (c) = (a) x (b)	$31.24

- Smoker Adjustment: Calculated by applying the tobacco surcharge (please see response to IDOI Objection Letter Item 12 above) to the Market Adjusted Index Rate as follows:

(a)	Market Adjusted Index Rate	$643.47
(b)	Tobacco Surcharge	1.014
(c)	Smoker Adjustment (c) = (a) x (b - 1)	$9.12

- Cost Sharing: Calculated by applying the tobacco surcharge, induced utilization, and paid to allowed value (please see response to IDOI Objection Letter Item 4 above) to the Index Rate as follows:

(a)	Index Rate	$670.70
(b)	Tobacco Surcharge	1.014
(c)	Induced Utilization	1.0485
(d)	Paid to Allowed	0.794
(e)	Cost Sharing (e) = [(a) / (b)] x (c) x (1 - d)	$142.82

- Fixed Costs: Consists of the following non-benefit expenses PMPM:

(a)	Broker Commissions	$6.18
(b)	PCORI Fee	$0.17
(c)	ACA Risk Adjustment User Fee	$0.08
(d)	Fixed Costs (d) = (a) + (b) + (c)	$6.42

- Variable Costs: Consists of the following percentage of premium non-benefit expenses:

(a)	Administrative Expenses	10.5%
(b)	Premium Tax	1.3%
(c)	Profit Margin	3.0%
(d)	Premium (Plan Adjusted Index Rate)	$621.20
(e)	Variable Costs (e) = [(a) + (b) + (c)] x (d)	$92.01

14. Please provide more detail around the Fixed costs and the Variable costs from the top of page 12.

Please see Section 10) Non-Benefit Expenses and Profit & Risk, on pages 8-9 of the Actuarial Memorandum for details on the Fixed and Variable costs.

15. With regard to the various metal levels, I think that as you go from bronze to gold, the benefits must be equal to or greater than the lower level metal level. It appears that your gold has lesser drug benefits than the silver plan.

The gradation referenced in your question is a requirement when comparing Silver CSR plans to Silver Standard plans. Per HHS Notice of Benefit and Payment Parameters for 2015 Final Rule - 45 CFR Part 156, § 156.420(e):

Decreasing cost sharing and out-of-pocket spending in higher AV silver plan variations. The cost sharing or out-of-pocket spending required of enrollees under any silver plan variation of a standard silver plan for a benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding cost sharing or out-of-pocket spending required in the standard silver plan or any other silver plan variation thereof with a lower AV.

However, it is our understanding that this gradation is a preference but not a requirement when comparing Gold and Silver Standard plans. This is validated by the Plan & Benefits Template validation process.

16. Please review the Hospital and Professional charges used in the URRT as they are much higher than the average.

As noted above, IUHP submitted a rate filing amendment via SERFF on June 4, 2014 which reflected revised assumptions regarding the Medicaid Spend Down population. The Hospital and Professional charges in the revised URRT have been reduced from the initial May 9th rate filing due to the revision in this particular assumption. We believe that the mix of services for IUHP may also differ from other carriers due to IUHP's status as a renowned teaching facility, which could lead to higher Hospital and Professional charges.

[INSERT LOGO]

Individual/Family/Child-Only Contract Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Indiana University Health Plans, premium payment is required before the requested effective date. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call [1 800-XXX-XXXX]. If you have questions about a previously submitted application, please call [1 800-XXX-XXXX].

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DISCLAIMER: The Affordable Care Act includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments of Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. **Please be advised that this Policy does not qualify for these affordability programs because it is not issued through the Indiana Marketplace.**

Section A – Coverage Information

Coverage Type (select one):

☐ Individual/Family ☐ Child-Only

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No. _____

Open Enrollment:

During the annual Open Enrollment period, you may apply for coverage, or change plans. The earliest Effective Date for the Initial Open Enrollment is [January 1, 2015]. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if Indiana University Health Plans, Inc. receives the application and initial premium payment between the 1st and 15th of the month. If Indiana University Health Plans, Inc. received the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st).

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Applications must be received during the Open Enrollment period. An applicant may enroll outside of the Open Enrollment period only if he/she experiences a Special Enrollment triggering event provided below. Notice of a triggering event must be received by Indiana University Health Plans, Inc. within [60] days of the triggering event.

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Special Enrollment Triggering Events:

Please check the triggering event:

☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;

☐ Loss of Minimum Essential Coverage due to dissolution of marriage;

☐ Marriage, birth, adoption or placement for adoption or appointment of guardianship;

☐ Violation of a Qualified Health Plan of a material contract provision;

☐ Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and result of an error, misrepresentation, or inaction of the Indiana Marketplace or the US Department of Health and Human Services;

☐ Newly ineligible for advance payments of premium tax credits or cost-sharing reductions.

☐ Relocation to a new service area;

☐ Determination that enrollment or non-enrollment in a Qualified Health Plan or an incorrect determination of ineligibility of advance payments of premium tax credits or cost-sharing reductions was the result of misconduct by a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities.

Please provide the date of the triggering event: _____

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)			

City	State	ZIP	County

Billing Address (street and P.O. Box if different from above)		

City	State	ZIP

Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth / /

Primary Phone Number ( )	Secondary Phone Number ( )	E-mail*

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this application.*

Last Name	First Name	MI	Relationship ☐ Spouse

Social Security Number*	Sex ☐ M ☐ F	Date of Birth / /

Section C – Spouse to be Covered Information (N/A if applying for Child-Only coverage)

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this application.*

Section D – Child Dependents to be Covered Information
(All fields must be completed. Attach a separate sheet if necessary).

Dependent information must be completed for all child dependents (if any) to be covered under this policy.

For family coverage, an eligible child dependent includes your child or your spouse's child, including any of the following until the child attains the age of 26: your natural child, stepchild, legally adopted child, child placed for the purpose of adoption, or child placed under legal guardianship or legal custody.

For child-only coverage, an eligible child dependent includes your child or your spouse's child, including any of the following until the child attains the age of 21: your natural child, stepchild, legally adopted child, child placed for the purpose of adoption, or child placed under legal guardianship or legal custody.

(Please list all dependents beginning with the eldest.)

Last Name	**First Name**	**MI**	**Sex**	**Date of Birth mm/dd/yyyy**	**Social Security Number***	**Relationship to Applicant**
			M ☐ F ☐			☐ Child ☐ Other:_____
			M ☐ F ☐			☐ Child ☐ Other: _____
			M ☐ F ☐			☐ Child ☐ Other: _____
			M ☐ F ☐			☐ Child ☐ Other: _____
			M ☐ F ☐			☐ Child ☐ Other: _____

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this application.*

Are all applicants listed on this application residents of Indiana? ☐ Yes ☐ No

If **YES**, please list the county of residence for each applicant:_____

_____

If **NO**, please list each applicant that is not a resident of Indiana:_____

_____

Has any applicant used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No

If **YES**, please list each applicant that has used tobacco products 4 or more times per week, on average, in the last 6 months:_____

_____

Section E – Medical Coverage

Select ONE Plan.

[☐ IU Health Plans Bronze Value]

[☐ IU Health Plans Bronze Enhanced]

[☐ IU Health Plans Silver Value]

[☐ IU Health Plans Silver Enhanced]

[☐ IU Health Plans Silver Value 87]

[☐ IU Health Plans Silver Enhanced 87]

[☐ IU Health Plans Silver Value 73]

[☐ IU Health Plans Silver Enhanced 73]

[☐ IU Health Plans Silver Value 94]

[☐ IU Health Plans Silver Enhanced 94]

[☐ IU Health Plans Gold Value]

[☐ IU Health Bronze HSA]

[☐ IU Health Plans Silver HSA]

[☐ IU Health Plans Silver HAS 87]

[☐ IU Health Plans Silver HSA 73]

[☐ IU Health Plans Silver HSA 94]

Health Savings Account Election:

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Indiana University Health Plans, Inc.'s banking partner. (Please fill in your social security number in Section B.)

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☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Indiana University Health Plans, Inc.'s banking partner.

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Section F – Pediatric Dental Coverage Certification

Child dependents age 19 and under are required to enroll in pediatric dental coverage that is certified by the Indiana

Marketplace. Indiana University Health Plans, Inc does not offer this mandated pediatric dental coverage.

☐ **YES**, I will enroll my child dependent(s) age 19 and under in a standalone dental plan that meets the mandated pediatric dental coverage requirement.

☐ **NO,** I will not enroll my child dependent(s) age 19 and under in a standalone dental plan that meets the mandated pediatric dental coverage requirement.

Section G – Other Health Coverage For Purposes of Coordination of Benefits Under the Policy

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, please list all applicants that are currently eligible for Medicare: _____

_____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No

If **YES**, please list all applicants current receiving such benefits and the reason they are receiving such benefits:

_____

_____

_____

Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____

Do you, or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If YES, please provide the following information:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for Indiana University Health Plans, Inc coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although Indiana University Health Plans, Inc.'s requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Indiana University Health Plans, Inc. does not mean that coverage has been approved. I may not assign any payment under my Indiana University Health Plans, Inc. program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Indiana University Health Plans, Inc. reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify Indiana University Health Plans, Inc. of any change that would make me or any dependent ineligible for coverage.
- [I understand Indiana University Health Plans, Inc. may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Indiana University Health Plans, Inc. automatic debit process and will only occur each time I send a check to Indiana University Health Plans, Inc. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.]
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Indiana University Health Plans, Inc. and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- ☐ By checking this box, I authorize and expressly consent that Indiana University Health Plans, Inc. and its affiliated companies may send e-mail communications instead of sending communications by mail, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting Indiana University Health Plans, Inc. customer service or online at [INSERT WEBSITE].
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Indiana University Health Plans, Inc. in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

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SIGNATURE PAGES FOLLOW

I give this authorization for and on behalf of any eligible dependents and myself if covered by Indiana University Health Plans, Inc. I am acting as their agent and representative.

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This application shall be altered solely by the applicant or with his or her written consent.

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your Indiana University Health Plans, Inc. appointed agent/broker:

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I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature **X**			Date
Agent/Broker Name (please print)		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.	
Agent/Broker ID/TIN	Agency ID/Parent TIN	City State ZIP	
Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail	

Authorization for Use of Protected Health Information

By signing below: I authorize Indiana University Health Plans, Inc., or an agent/broker, subsidiary or affiliate that has a business associate contract with Indiana University Health Plans, Inc., to obtain any medical records or other health history information concerning me and any family member listed on my application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations.

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This authorization is subject to revocation at any time by written notice to Indiana University Health Plans, Inc. except to the extent that Indiana University Health Plans, Inc. has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

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Unless previously revoked, this authorization is valid for 24 months from the date of signature.

Printed name of Applicant/Member X	Signature of Applicant/Member or his/her Legal Representative X	Date
Printed name of Spouse or Dependent Child* age 18 or over listed on this application X	Signature of Spouse or Dependent Child* or his/her Legal Representative X	Date
Printed name of Dependent Child* age 18 or over listed on this application X	Signature of Dependent Child* or his/her Legal Representative X	Date

**If listed on your application or change form, your spouse and each dependent child age 18 or over must sign above.*
If a legal representative signs on behalf of the applicant or spouse, a copy of the legal representative's authority must be attached to the application.
A photocopy of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.

[Insert logo left/center/right]

[INDIVIDUAL] [CHILD-ONLY] CONTRACT
[Issued through the Indiana Marketplace]
(herein called the "Contract")

[Product Name]

Issued by:

Indiana University Health Plans, Inc.
an Indiana domestic health maintenance organization
950 North Meridian Street
Indianapolis, Indiana 46204

[This coverage is issued through the Indiana Marketplace] [to provide coverage for a Dependent]. This Contract sets forth in detail [your] [the] rights and obligations [as a] [of the] Subscriber. It is important that you **read this Contract carefully.** [This Contract provides coverage only for enrolled Dependents.] This Contract includes limitations and exclusions. You should familiarize yourself with its terms and conditions before receiving Health Care Services. Capitalized terms have the meaning set forth in the Definitions sections.

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, you may return it to us or the agent who sold it to you within 10 days after your receipt. Your premium will be refunded and this Contract with be void from its start. Any Health Care Services received during this 10-day period are solely your responsibility.

Benefits under this Contract may vary depending on other medical expense insurance you may have.

If you have questions related to [your] [the] health insurance coverage [provided under this Contract], you may contact us at [toll free number] [or the Indiana Marketplace at www.healthcare.gov or [toll free number].]

[signature]
President

[**DISCLAIMER:** The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace.]

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TABLE OF CONTENTS **PAGE**

ARTICLE 1. DEFINITIONS

ARTICLE 2. ELIGIBILITY AND ENROLLMENT 9

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS 17

ARTICLE 4. COVERED SERVICES 20

ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS 55

ARTICLE 6. OBTAINING COVERED SERVICES 64

ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES. 66

ARTICLE 8. PAYMENT FOR COVERED SERVICES 75

ARTICLE 9. COORDINATION OF BENEFITS 77

ARTICLE 10. TERMINATION OF COVERAGE 82

ARTICLE 11. GENERAL PROVISIONS 87

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ARTICLE 1. . DEFINITIONS . 1¶
ARTICLE 2. . ELIGIBILITY AND ENROLLMENT. . 9¶
ARTICLE 3. . YOUR FINANCIAL OBLIGATIONS . 16¶
ARTICLE 4. . COVERED SERVICES . 19¶
ARTICLE 5. . NON-COVERED SERVICES AND EXCLUSIONS . 54¶
ARTICLE 6. . OBTAINING COVERED SERVICES . 63¶
ARTICLE 7. . REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE ¶
PROCEDURES. . 65¶
ARTICLE 8. . PAYMENT FOR COVERED SERVICES . 75¶
ARTICLE 9. . COORDINATION OF BENEFITS . 77¶
ARTICLE 10. . TERMINATION OF COVERAGE . 82¶
ARTICLE 11. . GENERAL PROVISIONS ... [1]

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ARTICLE 1. DEFINITIONS

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, [Dependent or Covered Person, either collectively or individually as appropriate to the reference] [who obtained this coverage through the Indiana Marketplace.]

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber [or the Dependent or Covered Person, either collectively or individually as appropriate to the reference].]

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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.

Approved Clinical Trial – a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

(a) A trial that is approved or funded by one, or a combination, of the following.

(a) The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services.

(b) The United States Food and Drug Administration.

(c) The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(d) The United States Department of Veteran’s Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(e) The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).

(f) The Centers for Disease Control and Prevention.

(g) The Agency for Health Care Research and Quality.

(h) The Centers for Medicare and Medicaid Services (CMS).

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(i) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks.

(j) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(k) A qualified non-governmental research entity in guidelines issued by the National Institutes of Health for center support grants.

(2) A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.

(3) A study or investigation done for drug trials which are exempt from the investigational new drug application.

For purposes of this definition, the term "life threatening condition" means any disease or condition from which death is likely unless the disease of condition is treated.

Behavioral Health – a physical or behavioral condition having an emotional or psychological origin or effect, including substance abuse. Behavioral Health Services include mental health services and substance abuse services.

Benefits – your right to payment for Covered Services under this Contract subject to the terms, conditions, limitations, and exclusions of this Contract.

Child or Children – a child of the Subscriber or Subscriber's spouse, including any of the following until the Child attains the age of [26] [21].

- Natural child,
- Stepchild,
- Legally adopted child,
- Child placed for the purpose of adoption, or
- Child placed under legal guardianship or legal custody.

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Child includes a child of any age who is incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 26 and the Subscriber principally supports the Child. Proof of the disability must be submitted to us within thirty-one (31) days of the child's [26th] [21st] birthday. For two years we may require proof of the child's continuing disability and dependency at reasonable intervals. After two years, we may require proof of the child's disability and dependency no more than once per year.

Coinsurance – a percentage of the Allowed Amount that [you] [the Subscriber] must pay for certain Covered Services. Coinsurance amounts are set forth in the Schedule of Benefits.

Contract – this individual contract issued by Indiana University Health Plans, Inc. which provides Benefits for Covered Services received by [the Subscriber] and enrolled Dependents. The term Contract includes the Schedule of Benefits, any application, amendments and riders.

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Copayment – a fixed amount [you pay] [the Subscriber pays] to a Provider for a Covered Service. The amount of a Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

Cosmetic Services – Health Care Services primarily intended to preserve, change or improve [your] [a Covered Person's] appearance or are furnished for psychiatric or psychological reasons.

Cost Sharing – the amount you are required to pay for Covered Services. Cost Sharing can be in the form of Copayments, Coinsurance or Deductibles.

Covered Person – [you or] any Dependent who meets all applicable eligibility requirements for coverage under this Contract, is enrolled as provided in this Contract, and for whom the required premium payment has been received by us.

Covered Services – Health Care Services [provided to a Covered Person] performed, prescribed, directed or authorized by a Provider and for which this 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 this Contract is in force.
- Not experimental/investigative.
- Authorized in advance by us if Precertification is required under this Contract.
- Not excluded or limited by this Contract.

Deductible – the amount [you] [the Subscriber] must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The amount of the Deductible is set forth in the Schedule of Benefits.

Dependent – an individual who [is either the Subscriber's legal spouse or a Child] [satisfies the eligibility requirements to enroll as a Dependent as set forth in Article 2].

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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 [website] 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.

Durable Medical Equipment – Medical equipment that:

- can withstand repeated use and is not disposable,
- is used to serve a medical purpose,
- is generally not useful to a person in the absence of a Sickness or injury,
- is appropriate for use in the home, and
- is the most cost-effective type of medical apparatus appropriate for the condition.

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Effective Date – the date when coverage under this Contract begins.

Emergency Medical Condition or Emergency – a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent 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 woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to a person's bodily functions.
- Serious dysfunction of a bodily organ or part of a person.

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, 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, 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 woman 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 woman or the unborn child.

FDA – the United States Food and Drug Administration.

Grace Period – the time period for payment of premium set forth in Article 3 Section B.

Health Care Services – medical or health care services, whether or not covered under this 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.

Indiana Marketplace – the health benefit exchange established by the Affordable Care Act for the state of Indiana.

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

Medically Necessary – those Health Care Services that we determine to be all of the following.

(4) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for [your] [the Covered Person's] illness, injury or disease.

(5) Required for the direct care and treatment or management of [your] [the Covered Person's] illness, injury or disease.

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(6) If not provided, [your] [the Covered Person's] condition would be adversely affected.

(7) Provided in accordance with generally accepted standards of medical practice.

(8) Not primarily for the convenience of [you] [the Covered Person], your family, the physician or another prescribing Provider.

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(9) 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 [your] [the Covered Person'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 [your] [the Covered Person'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 used in this 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 – 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 this Contract.

Non-Participating Hospital – a Hospital that has not entered into a contractual agreement with us or is not otherwise engaged by us to provide Health Care Services to Covered Persons under this 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 Covered Persons under this Contract.

[**Open Enrollment Period** – the number of days each year during which individuals may enroll in a Qualified Health Plan through the Indiana Marketplace.]

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[**Open Enrollment Period** – the number of days each year during which individuals may enroll for coverage under this Contract.]

Out of Pocket Maximum – the maximum amount you will pay for Covered Services in a Plan Year.

Outpatient – receipt of Health Care Services while not an Inpatient.

Participating Hospital – a Hospital 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 Covered Persons under this Contract.

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 Covered Persons under this Contract.

Plan Year – the calendar year during which this Contract is in effect. This Plan Year will be the 12 month calendar year except that if the Subscriber's Effective Date is after January 1st the Plan Year will begin on the Effective Date and end December 31st.

Precertification – 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.

Prescription Drug – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product, insulin, diabetic supplies, and syringes.

Prescription Legend Drug – A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

Primary Care Physician or 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 [your] [a Covered Person's] medical care under this Contract.

Provider – a doctor, Hospital, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

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.

(1) The Health Care Service that is the subject of the Approved Clinical Trial.

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(2) 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.

(3) 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.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) 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.

(6) A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.

(7) A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Qualified Health Plan – a health plan offered on the Indiana Marketplace that satisfies the requirements set forth under the Affordable Care Act (42 U.S.C. 18021(a)(1)).

[**Qualified Individual** – an individual who has been determined by the Indiana Marketplace to be eligible to enroll in a Qualified Health Plan.]

Schedule of Benefits – the part of this Contract that sets forth Cost Sharing, Out of Pocket Maximums, limitations and other information regarding [your] [a Covered Person's] coverage under this Contract.

Service Area – the counties in which we are authorized to offer a qualified health plan. Our Service Area is [insert list of counties].

Sickness – an illness, disorder, or disease.

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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.

[**Special Enrollment Periods** – enrollment periods administered by the Indiana Marketplace that occur outside of the Open Enrollment Period. Qualified Individuals and their dependents who are eligible for a Special Enrollment Period may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another during a Special Enrollment Period set for them by the Indiana Marketplace.]

[**Special Enrollment Periods** – enrollment periods administered by us that occur outside of the Open Enrollment Period.]

Spouse – the Subscriber's legal spouse.

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[**Subscriber** – an individual whose name is on the Contract and has enrolled a Dependent for coverage under this Contract. A Subscriber is the legal parent or legal guardian of the Covered Person. The Subscriber is not a Covered Person under this Contract.]

Therapeutic Abortion – an abortion performed to save the life or health of the mother, or as a result of incest or rape

Urgent Care Claim – 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 [your] [a Covered Person's] life, health or ability to reach and maintain maximum function.
- In the opinion of physicians familiar with [your] [a Covered Person's] condition, would subject [you] [a Covered Person] to severe pain that cannot be adequately managed unless we approve the Claim.

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ARTICLE 2. ELIGIBILITY AND ENROLLMENT.

[This Contract is available through the Indiana Marketplace. The Benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Indiana Marketplace to be Qualified Individuals.]

A. **[You][The Covered Person] as an Individual.** To be eligible for coverage as a Subscriber, an individual must meet the eligibility requirements listed below at the time of application and throughout the Plan Year.

(1) [Determined by the Indiana Marketplace to be a Qualified Individual for purposes of enrollment in a Qualified Health Plan.] [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective.]

(2) [Not incarcerated.] [Agree to pay the cost of the Premium that we require.]

(3) [A United States citizen or lawfully present non-citizen.] [Submit proof satisfactory to us to confirm Dependent eligibility.]

(4) [To be eligible as a Dependent, the person must be the Subscriber's Child.]

(5) [Under age 21.]

(6) A resident of the State of Indiana.

(7) Not entitled to or enrolled in Medicare or Medicaid.

(8) Not covered by any other group or individual health benefit plan.

B. [**Your Dependents.** To be eligible as a Dependent, another person must either be your Spouse or your Child.]

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C. [**Other Rules About Eligibility.** No one will be denied enrollment or re-enrollment in this Contract because of health status, or the existence of a pre-existing physical or mental condition.]

D. **Open Enrollment.**

(1) [Notice of Annual Open Enrollment. Each calendar year the Indiana Marketplace will provide you with a written annual open enrollment notification no earlier than September 1, and no later than September 30.]

[Notice of Annual Open Enrollment. Each calendar year we will provide you with a prior written notice of the Open Enrollment Period.]

(2) [2015 Open Enrollment Period. For this Plan Year beginning on January 1, 2015, the Open Enrollment period begins on November 15, 2014 and extends through February 15, 2015.]

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(3) [Effective Dates for Coverage Selected During 2015 Open Enrollment. For this Plan Year beginning on January 1, 2015, the following Effective Dates will apply:

(a) January 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace on or before December 15, 2014.

(b) February 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from December 16, 2014 through January 15, 2015.

(c) March 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from January 16, 2015 through February 15, 2015.]

(4) [Effective Dates for Coverage Selected During Annual Open Enrollment. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if we receive the application and initial premium payment between the 1st and 15th of the month. If we receive the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st)]

E. [**Special Enrollment Period.**

(1) Special Enrollment Triggering Events. The Indiana Marketplace must allow Qualified Individuals and [their] Dependents to enroll in a Qualified Health Plan or change from one Qualified Health Plan to another as a result of experiencing any of the following triggering events:

(a) Loss of Minimum Essential Coverage.

(b) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(c) Gaining status as a citizen, national, or lawfully present individual.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services ("HHS"), or its instrumentalities as evaluated and determined by the Indiana Marketplace. In such cases, the Indiana Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to a new service area of the Indiana Marketplace.

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(h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(i) Demonstration to the Indiana Marketplace, in accordance with guidelines issued by HHS, that [you or your] [the] Dependent meets other exceptional circumstances as the Indiana Marketplace may provide.

(j) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.)

(2) Indiana Marketplace Administration of Special Enrollments. For additional information on special enrollment triggering events and how to enroll in or change a Qualified Health Plan during a Special Enrollment Period, you should contact the Indiana Marketplace at [toll free number] or visit the Indiana Marketplace website at [www.healthcare.gov].

(3) Notice Requirement for Special Enrollments. Unless specifically stated otherwise in the applicable Indiana Marketplace rules, a [Qualified Individual or Dependent] [person] has sixty (60) days from the date of a special enrollment triggering event to select a Qualified Health Plan.

(4) Special Enrollment Effective Dates. The Effective Date for coverage obtained under this Contract during a Special Enrollment Period depends on the type of triggering event that qualified the individual and/or dependent for the Special Enrollment Period as well as the date the Indiana Marketplace received the Qualified Individual's Qualified Health Plan selection.

(a) For a Qualified Health Plan selection received from the first (1st) through the fifteenth (15th) day of any month, the Effective Date will be the first (1st) day of the following month; and

(b) For a Qualified Health Plan selection received from the sixteenth (16th) through the last day of any month, the Effective Date will be the first (1st) day of the second following month.]

E. [**Changes Affecting Eligibility and Special Enrollment Periods.**

(1) Special Enrollment Triggering Events. A Special Enrollment Period is a period during which an eligible individual who experiences certain triggering events or changes in eligibility may enroll in this Contract, outside of the Open Enrollment period.

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(2) Length of Special Enrollment Period. Unless otherwise stated, an eligible individual has 60 days from the date of a triggering event to enroll an eligible individual in this Contract.

(3) Triggering Events.

(a) Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, misrepresentation of a material fact or failure to pay premium.

(b) Loss of Minimum Essential Coverage due to dissolution of marriage.

(c) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Indiana Marketplace.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to new service area of the Indiana Marketplace.

(h) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.]

F. Adding New Dependents Under A Special Enrollment Period.

(1) Newly Born Children. If [you have] [the Subscriber has] a new Dependent as a result of birth, coverage for [your] [the] new Dependent is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for [your] [the] new Dependent shall continue beyond the initial thirty-one (31) days, provided [you request] [the Subscriber requests] [a Special Enrollment Period through the Indiana Marketplace to add [your] [the] new Dependent to this Contract] [you submit] [the Subscriber submits] [a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, if any[, within 60 days after the birth of the new Dependent]. [The Special Enrollment

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Period request must be submitted to the Indiana Marketplace within sixty (60) days after the date of birth. The Effective Date will be the date of birth.]

[If a Covered Person has a newborn child, coverage for the newborn child is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for the newborn child shall continue beyond the initial thirty-one (31) days, provided the newborn child meets the definition of Child under this Policy and the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace] [submits a form to us] to add the Child to this Contract and we receive payment for additional applicable premium, if any. If the newborn child does not meet the definition of Child under this Policy before the end of the initial thirty-one (31) days, coverage for the newborn child will terminate upon the thirty-second (32nd) day.]

(2) Adopted Children. If [you have] [the Subscriber has] a new Dependent as a result of adoption, coverage for [your] [the] new Dependent is automatically provided from the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting [you] [the Subscriber] custody of the child for purposes of adoption, for up to thirty-one (31) days. Coverage for [your] [the] new Dependent shall continue beyond the initial thirty-one (31) day period provided [you request] [the Subscriber requests] [a Special Enrollment Period through the Indiana Marketplace to add [your] [the] new Dependent to this Contract] [you submit] [the Subscriber submits] [a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, in any[, within 60 days following the date of adoption or placement for adoption]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of adoption or placement of adoption.] The Effective Date will be the earlier of the date of adoption or placement of adoption.

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(3) Adding a Child due to Award of Guardianship. If [you] [the Subscriber] or [your] [the Subscriber's] spouse files an application for an appointment of guardianship for a Child, an application to cover the Child under this Contract must be submitted to [the Indiana Marketplace] [us] within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

(4) Qualified Medical Child Support Order. If [you are] [the Subscriber is] required by a Qualified Child Support Order or court order, as defined by applicable state and federal law, to enroll [your] [his or her] Child under this Contract, and the Child is otherwise eligible for the coverage, [the Indiana Marketplace] [we] will permit [your] [the Subscriber's] Child to enroll in this Contract, and we will provide the benefits of this Contract in accordance with the applicable requirements of such court order.

A Child's coverage under this provision will not extend beyond the Dependent attaining age [26] [21]. Any claims payable under this Contract will be paid, at our discretion, to the Child or the Child's custodial parent or legal guardian, for any expenses paid by the Child, custodial parent or legal guardian. We will make

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information available to the Child, custodial parent or legal guardian on how to obtain benefits and submit claims to us directly.

(5) [Spouse] [New Dependent as a Result of Marriage] or Loss of Minimum Essential Coverage. If [you have] [the Subscriber has] a new Dependent as a result of marriage, or due to [your] [the] new Dependent's loss of Minimum Essential Coverage, [you] [the Subscriber] may elect to enroll [your] [the] new Dependent in this Contract, provided [you [request] [the Subscriber requests] [a Special Enrollment Period from the Indiana Marketplace to add your new Dependent to this Contract] [you submit] [the Subscriber submits] [to us a form to add your new Dependent] and we receive payment for additional applicable premium, if any[, within 60 days from the date of marriage or the loss of Minimum Essential Coverage]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of marriage or the loss of Minimum Essential Coverage.] The Effective Date will be on the first (1st) day of the month following the date of marriage or loss of Minimum Essential coverage.

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(a) "Loss of Minimum Essential Coverage" includes loss of eligibility for coverage as a result of any of the following:

(a) Legal separation or divorce.

(b) Cessation of dependent status (such as reaching the maximum age to be eligible as a Dependent under this Contract).

(c) Death of an employee; termination of employment; reduction in the number of hours of employment; or any loss of eligibility for coverage after a period that is measured by any of the foregoing.

(d) Individual who no longer resides, lives or works in the service area.

(e) A situation in which a health benefit plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Termination of employer contributions.

(g) Exhaustion of COBRA continuation of coverage.

(b) "Loss of Minimum Essential Coverage" does not include termination or loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(b) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact

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If [you do] [the Subscriber does] not enroll [your] [a] new Dependent during the time periods stated above, [he or she] [the new Dependent] will not be added to [your] [the] coverage [under this Contract] until the next Open Enrollment Period.

G. Notification of Changes.

(1) Responsibility to Notify [the Indiana Marketplace] [Us]. [You are] [The Subscriber is] required to notify [the Indiana Marketplace] [us] of any changes in [your] [a Covered Person's] eligibility [or the eligibility of your Dependents] for Benefits under this Contract. [The Indiana Marketplace] [We] must be notified of any changes in eligibility as soon as possible, but not later than thirty (30) days from the date of the change in eligibility status. This may include changes in address, marriage, divorce, death, incarceration, change of Dependent disability or dependency status, change in Medicare or Medicaid eligibility status, etc. Notice of a change in eligibility must be provided to [the Indiana Marketplace in a form required and approved by the Indiana Marketplace] [us in writing and on a form approved by us]. Such notifications must include all information required to effectuate all necessary changes.

(2) Failure to Notify [Indiana Marketplace] [Us]. Failure to notify [the Indiana Marketplace] [us] of persons no longer eligible for coverage under this Contract will not obligate us to provide services to those no longer eligible. Our acceptance of payments for persons no longer eligible for services will not obligate us to pay for such services.

(3) Effective Date of Termination Due to Change in Eligibility. Regardless of whether we receive timely notice, a Covered Person's coverage will terminate on the [last day of the month following the date] [day] such Covered Person ceases to be eligible for coverage under this Contract. [We have the right to bill [you] [the Subscriber] for the cost of any Health Care Services provided to a Covered Person during the period such Covered Person is not eligible under this Contract.] If [you think] [the Subscriber thinks] there are reasons coverage of the person experiencing the change should continue, [you] [the Subscriber] must notify [the Indiana Marketplace] [us] of the reasons for the continuation of the coverage no later than thirty-one (31) days after the date coverage for the Dependent would otherwise terminate.

(4) [Statements and Forms. You shall complete and submit to us applications and other forms or statements we may request. You represent to the best of their knowledge and belief that all information contained in such applications, forms, questionnaires, and statements submitted to us is true, correct and complete. You understand that all rights to Benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you or a Covered Person may result in termination or rescission of coverage.]

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ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A. Premium.

(1) [You] [The Subscriber] must pay premium to us each month for coverage under this Contract. [Your] [The Subscriber's] premium rate is determined using the following acceptable rating factors: age, tobacco use, family size and geography.

(a) Tobacco use impacts the determination of [your] [the] premium. [Upon enrollment through the Indiana Marketplace] [During the enrollment application process], [you] [the Subscriber] will attest to tobacco use by [you and/or you] [his and/or her Dependents]. If [you report] [the Subscriber reports] false or incorrect information about tobacco use, we may retroactively apply the appropriate tobacco rating factor to [your] [the Subscriber's] premium as if the correct information had been accurately reported from the Effective Date.

(b) [Your] [A Covered Person's] age impacts the determination of [your] [the] premium rate. If [your] [a Covered Person's] age has been misstated, we will adjust the premiums to the amount premiums would have been if purchased at the correct age.

(2) [You] [The Subscriber] will receive a monthly bill for your premium. [Your] [The Subscriber's] payment is due by the date stated in [your] [the Subscriber's] bill subject to the any applicable Grace Period stated in this Contract. [You] [The Subscriber] must pay [your] [the] premium when it is due for coverage to continue.

(3) We reserve the right to change the premium on an annual basis. We will provide [you] [the Subscriber] with thirty (30) days prior written notice of any change in the premium.

(4) [Your] [The Subscriber's] premium may change if Dependents are enrolled or disenrolled in [your] [the] coverage [under this Contract]. If a premium increase is necessary, we will bill [you] [the Subscriber] for the additional amount due. If this amount is not paid, this Contract will be cancelled at the end of the applicable Grace Period and [you] [the Subscriber] will receive a refund of any unearned premium. If a decrease in premium is appropriate we will notify [you] [the Subscriber] of the decrease and refund any excess premium to [you] [the Subscriber].

(5) If premium has been paid for any period of time after the date [you cancel] [the Subscriber cancels] this Contract, we will refund that premium to [you] [the Subscriber]. The refund will be for the period of time after [your] coverage [under this Contract] ends. If a Covered Person dies while this Contract is in force, we will refund any premium paid for such Covered Person for any period after the date of the Covered Person's death [to you or your estate].

B. Grace Period.

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(1) [General Grace Period.] Following payment of the initial premium, a Grace Period of thirty (30) days shall be granted for the payment of any premium. This Grace Period shall not extend beyond the date this Contract terminates. During the Grace Period this Contract shall continue in force. Any claims incurred and submitted during the Grace Period will not be considered for payment until premium is received. If premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of coverage.

(2) [Grace Period for Persons Receiving Advance Payments of the Premium Tax Credit. [If you are] [If the Subscriber or Covered Person is] receiving advance payments of the premium tax credit and at least one full month's premium has been paid during this Plan Year, a Grace Period of three (3) consecutive months shall be granted for the payment of any premium. During this 3-month Grace Period, we shall do all of the following listed below.

(a) Pay for Covered Services during the first (1st) month of the Grace Period and may pend claims for Covered Services rendered to [you] [the Covered Person] in the second and third months of the Grace Period.

(b) Notify the Department of Health and Human Services of such non-payment

(c) Notify Providers of the possibility for denied claims during the second and third months of the Grace Period.]

C. Deductible.

(1) The Deductible is the amount [you] [the Subscriber] must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The Deductible is set forth in the Schedule of Benefits.

(2) Copayments do not count towards the Deductible.

D. Coinsurance.

(1) Coinsurance is a percentage of the Allowed Amount that [you] [the Subscriber] must pay for Covered Services. [You are] [The Subscriber is] responsible for payment of Coinsurance after [you have] [the Subscriber has] met the Deductible and until [you reach] [the Subscriber reaches] the Out of Pocket Maximum. Coinsurance is set forth in the Schedule of Benefits.

(2) [Your] Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

E. Copayments.

(1) Copayments are a fixed amount [you pay] [the Subscriber pays] to a Provider for a Covered Service. Copayments are typically paid when [you receive] [the

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Subscriber receives] the Covered Service. The amount of the Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

(2) Copayments do not apply to the Deductible. Copayments apply towards the Out of Pocket Maximum.

F. Out of Pocket Maximum.

(1) The Out of Pocket Maximum is the maximum amount [you] [the Subscriber] will pay for Covered Services in a Plan Year. The Out of Pocket Maximum is listed on the Schedule of Benefits.

(2) Once the Out of Pocket Maximum is reached, we will pay 100% of the Benefits for Covered Services.

(3) Copayments, Coinsurance and the Deductible apply towards the Out of Pocket Maximum.

G. Payments for Non-Covered Services. [You are] [The Subscriber is] responsible for payment of all expenses for Non-Covered Services.

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ARTICLE 4. COVERED SERVICES

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides Benefits for the following Covered Services. Payment for Covered Services is limited by any applicable Coinsurance, Copayment, or Deductible set forth in this Contract including the Schedule of Benefits. To receive maximum Benefits for Covered Services, [you must follow] the terms of this Contract [must be followed], including receipt of care from a Primary Care Physician and Participating Providers as well as obtaining any required Precertification.

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You are responsible for all expenses incurred for Non-Covered Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

A. Ambulance Services.

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

(a) From your home, scene of accident or medical Emergency to a Hospital,

(b) Between Hospitals,

(c) Between a Hospital and Skilled Nursing Facility, or

(d) From a Hospital or Skilled Nursing Facility to your home.

(2) Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

(3) Other vehicles which do not meet the definition of Ambulance Services are not Covered Services. Ambulette services are Covered Services when appropriate.

(4) Ambulance Services are a Covered Service only when Medically Necessary, except:

(a) When ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse, or

(b) When a Covered Person is required by us to move from a Non-Participating Provider to a Participating Provider.

(5) Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health.

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(6) Non-Covered Services for Ambulance include but are not limited to:

(a) A trip to a physician's office or clinic,

(b) A trip to a morgue or funeral home, or

(c) Any ambulance usage for the convenience of a Covered Person, family or Provider.

B. Behavioral Health Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Covered Services include:

(a) Inpatient services. Individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

(b) Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

(c) Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health conditions. Intensive Outpatient programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient programs may offer group, DBT, individual, and family services.

(d) Outpatient Treatment, or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

(2) Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

(3) To assist you in obtaining appropriate and quality care, we will ask for a treatment plan after you have been evaluated after 10 Outpatient visits. We may discuss the goals of treatment and changes in the treatment plan, including

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alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

(4) Non-Covered Services include the following.

(a) Custodial or domiciliary care.

(b) Supervised living or halfway houses.

(c) Services or care provided or billed by a residential treatment center, school, halfway house.

(d) Custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(e) Services related to non-compliance of care if the Covered Person ends treatment for substance abuse against the medical advice of the Provider.

C. Routine Care Costs as Part of a Cancer or Other Life Threatening Disease or Condition Clinical Trial.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits are available for Routine Care Costs rendered as part of an Approved Clinical Trial if the services are otherwise Covered Services under this Contract.

(2) Your Primary Care Physician must give us notice of your participation in an Approved Clinical Trial.

(2) Non-Covered Services include the following.

(a) A Health Care Service that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient.

(b) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service or investigational drug that is the subject of the clinical trial.

(c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.

(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the clinical trial.

(e) An item or drug provided by the clinical trial sponsors free of charge for any patient.

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(f) A service, item, or drug that is eligible for reimbursement by a person or entity other than us, including the sponsor of the clinical trial.

D. Dental Services Related to an Injury.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient services, Physician Home Visits and Office Services, Emergency Services and Urgent Care Center Services for dental work and oral surgery are Covered Services if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Covered Person's condition.

(2) Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

(3) For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

(4) Covered Services include, but are not limited to the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations
- Prosthetic services
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia

(5) Anesthesia and Hospital charges for dental care for a Covered Person less than 19 years of age or a Covered Person who is physically or mentally disabled, are covered if the Covered Person requires dental treatment to be given in a Hospital or Outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Covered Person's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

E. Diabetic Equipment, Education and Supplies.

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For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when ordered in writing by a physician or a podiatrist and provided by a physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

(2) Covered Services include physician prescribed equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical Equipment and Appliances", "Preventive Care Services", and "Physician Home Visits and Office Services".

F. Diagnostic Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services include the following.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).

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- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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

(3) For Diagnostic services other than those approved to be received in a physician's office, you may be required to use a laboratory that is a Participating Provider.

(4) When Diagnostic radiology is performed in a Participating Provider's Office, no Copayment is required, however, any Coinsurance will still apply.

G. Emergency Care Services and Urgent Care Center Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit limitation. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits for treatment of an Emergency Medical Condition and Emergency screening and stabilization services without Precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions.

(2) Benefits for Emergency Care include facility costs and physician services, supplies and Prescription Drugs charged by that facility.

(3) Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Copayment or Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify us or verify that your physician has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary. If your Provider is a Non-Participating Provider, you will be financially responsible for any care we determine is not Medically Necessary.

(4) Often an urgent rather than an Emergency Medical Condition exists. An urgent medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Such medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Primary Care Physician prior to receiving care for an urgent medical problem and your Primary Care Physician

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authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Care Services.

H. Home Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Covered Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Care Services.
- Nutritional Guidance.
- Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Health Care Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Care Services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services in the home (except for Massage, Music, and Manipulation Therapy). Home Care visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

(3) Non Covered Services include the following.

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

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(4) Home infusion therapy will be paid only if you obtain Precertification. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

I. Hospice Services.

For all Covered Services, see the schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit limitations. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) 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 (6) months or less, as certified by the attending physician and hospice medical director. Covered Services will continue if the Covered Person lives longer than six (6) months, provided the hospice medical director or other hospice physician recertifies that the Covered Person is terminally ill.

(2) Covered Hospice Services include the following.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Care Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

(3) Non-Covered Services include services provided by volunteers and housekeeping services.

J. Inpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Inpatient services include the following.

(a) Charges from a Hospital, Skilled Nursing Facility or other Provider for room, board and general nursing services.

(b) Ancillary services.

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(c) Professional services from a physician while an Inpatient.

(2) Room, Board, and General Nursing Services include either of the following.

(a) A room with two or more beds or a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

(b) A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

(3) Ancillary (Related) Services include any of the following.

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

(4) Professional Services include the following.

- Medical care visits limited to one visit per day by any one physician.
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, and EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

(5) When a Covered Person is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

K. Maternity Services.

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For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

(2) If the Covered Person is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider for the Health Care Services to be Covered Services. If the Covered Person is pregnant on her Effective Date and is in her second or third trimester of pregnancy, she may receive Benefits for Health Care Services from a Non-Participating Provider if she requests and receives written approval from us.

(3) If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance or Copayment.

(4) If Maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

(5) Coverage for the Inpatient postpartum stay for a Covered Person and her newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if both or the following are met.

(a) In the opinion of your attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the following.

- The antepartum, intrapartum, and postpartum course of the mother and infant.
- The gestational stage, birth weight, and clinical condition of the infant.
- The demonstrated ability of the mother to care for the infant after discharge.
- The availability of post discharge follow-up to verify the condition of the infant after discharge.

(b) The mother of the newborn child agrees with the recommendation for a shorter length of stay.

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(6) Covered Services include at-home post-delivery care visits at your residence by a physician or nurse performed no later than 48 hours following discharge from the Hospital. Coverage for this visit includes, but is not limited to parent education, assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At your discretion, this visit may occur at the physician's office.

(7) Covered Services include the following tests and examinations given at the earliest feasible time to the newborn child for the detection of the following disorders.

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

L. Medical Supplies, Durable Medical Equipment and Appliances.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Medical and Surgical Supplies. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a physician's office, including but not limited to, Depo-Provera and Remicade. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

(a) Covered Services include the following.

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.

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- Clinitest.
- Needles/syringes.
- Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not Covered Services.

(b) Non-Covered Services include the following.

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Medijectors.

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

(3) Durable Medical Equipment - The rental (or, at our option, the purchase) of Durable Medical Equipment prescribed by a Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples of Durable Medical Equipment include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price.

(a) We will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Covered Person, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is a Covered Service.

(b) Covered Services include the following.

- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pump for IV fluids and medicine.
- Glucometer.

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- Tracheotomy tube.
- Cardiac, neonatal and sleep apnea monitors.
- Augmentive communication devices are Covered Services when we approve based on the Covered Person's condition.
- CPAP machines when indicated for sleep apnea.

(c) Non-Covered Services include the following.

- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats.
- Rental of equipment if the Covered Person is in a Facility that is expected to provide such equipment.
- Translift chairs.
- Treadmill exerciser.
- Tub chair used in shower.

(4) Prosthetics. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

(a) Prosthetic devices should be purchased not rented. Applicable taxes, shipping and handling are Covered Services.

(b) Covered Services include the following.

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Plan Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction

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is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered Services. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be a Covered Service.

- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Plan Year).

(c) Non-Covered Services include the following.

- Dentures, replacing teeth or structures directly supporting teeth.
- 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.

(5) Orthotic Devices. The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered Services. The casting is a Covered Service when an orthotic appliance is billed with it, but not if billed separately.

(a) Covered Services include the following.

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

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(b) Orthotic appliances may be replaced one time per Plan Year unless specifically approved in writing by us. Additional replacements will be allowed for Covered Persons under age 18 due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

(c) Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

(d) Non-Covered Services include the following.

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

(6) Prosthetic limbs & Orthotic custom fabricated brace or support. Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be a Covered Service if they are determined by your physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities, and are not solely for comfort or convenience.

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

(b) Prosthetic limbs and orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

(7) Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below, as approved by us.

(a) The repair, adjustment or replacement of the purchased equipment, supply or appliance is a Covered Service if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.

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- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

(b) Replacement of purchased equipment, supplies or appliance may be a Covered Service if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

(c) Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

M. Outpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital or other facility as determined by us. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation.

(2) Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to Article 3 Section B for Behavioral Health Services covered by this Contract.

(3) Professional charges only include services billed by a physician or other professional.

(4) When Diagnostic Services or other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Service, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

(5) For Emergency Care refer to the section titled Emergency Services.

N. Autism Spectrum Disorder Services.

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For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Autism Spectrum Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(2) Coverage is provided for the treatment of Autism Spectrum Disorders, including behavioral therapies such as Applied Behavior Analysis (ABA). Benefits are limited to Health Care Services prescribed by your physician in accordance with a treatment plan. Coverage for Health Care Services will be provided as prescribed by your treating physician in accordance with the treatment plan.

(3) Any exclusion or limitation in this Contract in conflict with the coverage described in this section will not apply.

(4) Coverage for Autism Spectrum Disorders will not be subject to limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Contract.

O. Physician Home Visits and Office Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service a Health Care Service must be Medically Necessary.

(1) Covered Services include care provided by a physician, including employees of the physician such as an advanced practice nurse or physician assistant, in his/her office or your home. Refer to the sections titled Preventive Care, Maternity Care, Home Care Services, and Behavioral Health Care Services for services covered by this Contract. For Emergency Care refer to the Emergency Services section.

(2) Office visits for medical care and consultations to examine, diagnose, and treat a Sickness or injury performed in the physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a physician's office, no Copayment is required however Coinsurance will apply.

(3) Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

(4) Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

(5) Surgery and surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

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(6) Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a physician or other professional Provider.

P. Preventive Care Services. Preventive Care Services include, Outpatient services and Office Services. Screenings and other Health Care Services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Covered Persons who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

(2) Preventive Care Services in this section shall meet requirements as determined by federal and state law.

(a) Health Care Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF. Covered Services include the screenings for following.

- Breast cancer.
- Cervical cancer.
- Colorectal cancer.
- High Blood Pressure.
- Type 2 Diabetes Mellitus.
- Cholesterol.
- Child and Adult Obesity.
- For Covered Persons age 15 – 65 and other ages at increased risk, Human Immunodeficiency Virus (HIV)
- Depression for adults
- Screening for alcohol misuse

(b) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(c) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Well Baby visits and care.
- Newborn screening for hearing
- Lead screening for children at risk for exposure
- Depression screening for adolescents

(d) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

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- Women's contraceptives, sterilization procedures, and counseling. This includes generic drugs only, unless there is no generic equivalent, obtained from a Participating Pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms and intrauterine devices (IUDs) are also covered. When generic equivalents are available, prescription brand name contraceptives will not be covered under the Preventive Care benefit. Instead, prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the Prescription Drug Benefits section.
- Breastfeeding support, supplies, and counseling.
- Gestational diabetes screening.

(3) Covered Services also include the following services required by state law:

(a) Breast Cancer Screening. The following are Covered Services.

(a) If the female Covered Person is at least 35 years of age, one (1) baseline breast cancer screening mammography performed before she becomes 40 years of age.

(b) If the female Covered Person is less than 40 years of age and is high risk, one (1) breast cancer screening mammography performed every year. A woman is considered "high risk" if she meets at least one (1) of the following.

(A) Has a personal history of breast cancer.

(B) Has a personal history of breast disease proven benign by biopsy.

(C) Has a mother, sister, or daughter who has had breast cancer.

(D) Is at least 30 years of age and has not given birth.

(c) Any additional mammography views that are required for proper evaluation.

(d) Ultrasound services, if determined Medically Necessary by the physician treating the Covered Person.

(b) Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Service for a Covered Person under the age of fifty (50) if the Covered Person is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsymptomatic Covered Person, in accordance with the current American Cancer Society guidelines.

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(c) Diagnostic Prostate Cancer Screening. If male Covered Person is at least 50 years of age, one (1) prostate specific antigen test annually is a Covered Service. If a male Covered Person is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test annually is a Covered Service.

Q. Surgical Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes the following.

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

(2) The surgical fee includes normal post-operative care.

(3) We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact us for more information.

(4) Covered Surgical Services include the following.

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

R. Reconstructive Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

(2) Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract.

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(3) Covered Services are limited to the following.

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

(4) For a Covered Person who has undergone a mastectomy Covered Services include the following.

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

S. Sterilization.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

Sterilization is a Covered Service.

T. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

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(2) Covered Services include removable appliances for repositioning and related surgery, medical care, and diagnostic services.

(3) Non-Covered Services include the following:

- Fixed or removable appliances that involve movement or repositioning of the teeth.
- Repair of teeth (fillings).
- Prosthetics (crowns, bridges, dentures).

U. Therapy Services.

Benefits are provided for therapy services that can be Rehabilitative or Habilitative. For purposes of this section and the Schedule of Benefits, the following definitions apply:

- Rehabilitation refers to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech therapy and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Physical therapy.

(a) Physical therapy includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve

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

(b) Non-Covered Services include the following.

- 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.

(3) Speech Therapy. Speech therapy for the correction of a speech impairment.

(4) Occupational Therapy. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

(a) Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

(b) Non-Covered Services include the following.

- Supplies (looms, ceramic tiles, leather, utensils).
- Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again.
- General exercises to promote overall fitness and flexibility.
- Therapy to improve motivation.
- Suction therapy for newborns (feeding machines).
- Soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial.
- Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

(5) Manipulation Therapy. Manipulation Therapy includes osteopathic/chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

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(a) Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any limitation for Manipulation Therapy services as specified in the Schedule of Benefits.

(b) Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

(6) Other Therapy Services.

(a) Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

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

(c) Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage this Contract will not require you to receive dialysis treatment at a Participating Provider that is a dialysis facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Participating Dialysis Facility is more than 30 miles from your home, you may, upon our prior written consent, receive treatment at a Non-Participating Provider that is a dialysis facility nearest to your home as Covered Service.

(d) Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

(e) Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to:

- Introduction of dry or moist gases into the lungs.
- Nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication.
- Continuous positive airway pressure ventilation (CPAP).
- Continuous negative pressure ventilation (CNP).
- Chest percussion.
- Therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers.
- Broncho-pulmonary drainage.
- Breathing exercises.

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

V. Physical Medicine and Rehabilitation Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

(2) The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting. Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

(3) Non-Covered Services include the following.

- Admission to a Hospital mainly for physical therapy.
- Long term rehabilitation in an Inpatient setting.

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

W. Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

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- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Cost Sharing.

(2) "Covered Transplant Procedure" includes any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

(3) "Transplant Benefit Period" starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.

(4) Transplant services require Precertification.

(5) Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are a Covered Service as routine Diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

(6) Transportation and Lodging. This Contract will provide assistance with reasonable and necessary travel expenses as determined by us when you obtain Precertification and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when claims are filed.

(7) Non-Covered Services for transportation and lodging include the following.

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- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

X. Prescription Drug Benefits.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Pharmacy Benefits Manager (PBM).

(a) The Prescription Drug benefits are managed by our Pharmacy Benefits Manager or PBM. The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy, a Specialty Pharmacy, and provides clinical management services. The management and other services the PBM provides include, making recommendations to, and updating, the "covered Prescription Drug list" (the "covered Prescription Drug list" is referred to as the "Formulary"), managing a network of retail pharmacies, operating a mail service pharmacy, and operating a Specialty Pharmacy network.

(b) The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of Prescription Drug benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions or drug/pregnancy concerns. You may request a copy of the Formulary by calling the Customer Service telephone number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage.

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(c) For certain Prescription Drugs, the prescribing Provider may be asked to provide additional information before the PBM and/or we can determine Medical Necessity. We may, in our sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer.

(d) Precertification may be required for certain Prescription Drugs (or the prescribed quantity of a particular Prescription Drug). At the time you fill a prescription, the Participating Pharmacy is informed of the Precertification requirement through the Participating Pharmacy's computer system. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee which is reviewed and adopted by us.

(e) For a list of the current Prescription Drugs requiring Precertification, please contact the Customer Service telephone number on the back of your Identification Card or go to our website at [insert url to formulary]. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage. Your Provider or Participating Pharmacy may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under this Contract.

(2) Therapeutic Substitution of Prescription Drugs. This is a voluntary program designed to inform Covered Persons and Providers about possible substitutes to certain Prescription Drugs. We, or the PBM, may contact you and your prescribing Provider to make you aware of substitution options. Therapeutic substitutes may also be initiated at the time the Prescription Drug is dispensed.

(a) Only you and your Provider can determine whether the therapeutic substitute is appropriate for you.

(b) For questions or issues involving therapeutic substitutes, call the Customer Service telephone number on the back of your Identification Card.

(c) The therapeutic substitutes list is subject to periodic review and amendment.

(3) Step Therapy. Step therapy protocol means that a Covered Person may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Covered Persons access high quality yet cost effective Prescription Drugs. If a Provider decides that the monitored medication is needed the Precertification process is applied.

(4) Participating Specialty Pharmacy. The PBM's Specialty Pharmacy is available to Covered Persons who use Specialty Drugs.

(a) "Specialty Drugs" are Prescription Legend Drugs that are one of the following:

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

(b) Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, subject to a day supply limit for retail and mail service, and the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

(c) Questions regarding Specialty Drugs can be directed to the Customer Service telephone number on the back of your Identification Card.

(d) You may obtain a list of the Participating Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your Identification Card, or review the lists on our website at [insert address].

(5) Covered Services include the following.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Self-administered contraceptives, including oral contraceptives, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the Preventive Care section, please see that section for more details.
- Selected drugs to eliminate or reduce dependence on, or addiction to tobacco and tobacco products.
- Injectables.
- Selected preventive medications are covered with no Copayment or Coinsurance if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations. These medications include the following: vitamin D supplementation, folic acid supplementation, aspirin and oral fluoride supplementation.

(6) In addition to the Exclusions set forth in Article 4, Non-Covered Services include the following.

- Prescription Drugs dispensed by any mail service program other than the PBM's mail service pharmacy, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.

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- Off label use, except as otherwise prohibited by law or as approved by us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription.
- Drugs not approved by the FDA except as otherwise prohibited by law.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a physician. This does not apply to drugs used in conjunction with a Diagnostic Service, with chemotherapy performed in the office or drugs eligible for coverage under the Medical Supplies benefit.
- Any drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by this Contract, or which exceed any age limits established by us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility drugs.
- Human growth hormone for children born small for gestational age.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact us for additional information on these Prescription Legend Drugs.
- Refills of lost or stolen medications.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, unless otherwise required by law or approved by us. "Clinically equivalent" means drugs that, for the majority of persons, can be expected to produce similar therapeutic outcomes for a disease or condition.

(7) If you have questions regarding whether a particular Prescription Drug is covered and which Tier a Prescription Drugs fall into, please call the Customer Service telephone number on the back of your Identification Card, or visit our website at [website address].

(8) Each Prescription Drug may be subject to a Deductible, Coinsurance or Copayment. If the prescription includes more than one covered Prescription Drug, a separate Coinsurance or Copayment will apply to each covered Prescription Drug. Your Copayment will be the lesser of your scheduled Copayment or the Allowable Amount.

(9) The number of days' supply of a Prescription Drug which you may receive is limited. The days' supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days' supply allowed for under this Contract, you should ask your Pharmacist

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to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

(10) Your Copayment or Coinsurance amount may vary based on whether the Prescription Drug has been classified by us as a first, second, third, fourth or fifth "Tier" Prescription Drug. The determination of Tiers is made by us based upon clinical information, and where appropriate the cost of the Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

(a) Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This Tier will contain low cost and preferred generic medications as well as selected preventive medications that are covered with no Coinsurance or Copayment if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations.

(b) Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This Tier will contain non-preferred generic medications.

(c) Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This Tier will contain preferred brand name medications.

(d) Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This Tier will contain non-preferred brand name medications.

(e) Tier 5 Prescription Drugs will have a higher/comparative Coinsurance or Copayment than those in Tier 4. This Tier will contain medications that are considered Specialty Drugs.

We have established a Pharmacy and Therapeutics Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Precertification criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives. The Pharmacy and Therapeutics Committee also determines, where appropriate, the cost of a Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one drug over another in our patient program, and, where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by

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mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

(11) From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, generic, mail service, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Prescription Drugs or preferred products for a limited period of time.

(12) The amount of Benefits paid is based upon whether you receive the Covered Services from a Participating Pharmacy, including a Participating Specialty Pharmacy, a Non-Participating Pharmacy, or the PBM's mail service program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug.

(13) How you obtain your Benefits depends upon whether you go to a Participating or a Non-Participating Pharmacy.

(a) Participating Pharmacy – Present your written prescription from your physician and your Identification Card to the pharmacist at a Participating Pharmacy. The Participating Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment or Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge and you believe the Prescription Drug should be covered, ask your pharmacist for an itemized receipt and submit it to us for reimbursement consideration.

(b) Specialty Drugs - You or your Provider can order your Specialty Drugs directly from a Participating Specialty Pharmacy, simply call the Customer Service telephone number on the back of your Identification Card. Your Specialty Drug may need Precertification prior to dispensing. Upon approval, your Specialty Drug will be delivered to your physician's office/your specified delivery location based on the physician's order. A clinician will be available to answer any questions you may have in regard to the Specialty Drug and the instructions.

(c) Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy, including a Non-Participating Specialty Pharmacy. You must submit a claim for reimbursement consideration as set forth in Article 8 Section C.

(d) The Mail Service Program – Complete the order and patient profile form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have your physician fax the prescription to the mail service pharmacy. Your physician may also phone in the prescription to the mail service pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the mail service pharmacy when you request a prescription.

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(14) Drug Exception Program. This is a program designed to allow Covered Persons to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. Please call the Customer Service number on the back of your Identification Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or are currently undergoing a course of treatment using a Prescription Drug that is not on the Formulary, you may request an expedited review of your request for a drug exception. In such circumstances, we will provide you or your Designated Representative with our decision within twenty-four (24) hours after we receive your request.

Y. Pediatric Vision Services. The following Health Care Services are Covered Services only for Covered Person through the age of nineteen (19). The Contract only provides Benefits for vision care that is listed in this section.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A complete pediatric eye exam. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together. The exam may include the following.

- Case History.
- Cover test.
- Ocular Motility.
- Neurological Integrity.
- External Exam.
- Internal Exam.
- Retinoscopy.
- Phorometry testing.
- Point refraction.
- Tonometry.
- Opthalmoscopic exam.
- Confrontation Visual Fields.
- Biomicroscopy.
- Color Vision Testing.
- Diagnosis/Prognosis.
- Recommendations.

(2) Eyeglass Lenses. Lens options include a choice of plastic or polycarbonate. Lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include up to 55 mm in single vision, bifocal, trifocal or lenticular.

(3) Frames. This Contract offers a selection of frames that are covered.

(4) Contact Lenses. Coverage includes the following.

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(a) Contact Lens professional fitting fees.

(b) Elective Contact Lenses (elective contact lenses are contacts that are chosen for comfort or appearance).

(c) Non-Elective Contact Lenses are only provided for the following medical conditions.

- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when the patient's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

(d) Medically Necessary contact lenses are available in lieu of ophthalmic lenses and may be subject to Copayments, Coinsurance and limitations. The Provider determines a patient's qualifying criteria at examination and evaluation, and will obtain any necessary Precertification from us for these services.

(5) Low Vision Benefits

(a) Comprehensive Low Vision Exam.

(b) Optical/Non-optical aids.

(c) Supplemental testing.

(6) Non-Covered Services include services incurred for, or in connection with, any of the items below.

- Non-elective contact lenses for any Covered Person who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- For safety glasses and accompanying frames.
- For Inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Covered Person has reached the normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Contract.
- Cosmetic lenses or options.
- Blended lenses.

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- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Vision services for Covered Persons over the age of nineteen (19) unless specifically stated in this Contract.

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ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS

A. Non-Covered Services.

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This Article 5 sets forth services that are excluded from coverage under this Contract and therefore are Non-Covered Services. Non-Covered Services are not covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

B. Exclusions. The following are Non-Covered Services:

(1) Services that we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.

(2) Services received from an individual or entity that is not a Provider.

(3) Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.

(4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

(5) Services provided as benefits by any governmental unit, unless otherwise required by law or regulation.

(6) Services for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

(7) Services for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

(8) Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

(9) Court ordered testing or care unless Medically Necessary.

(10) Services for which you have no legal obligation to pay in the absence of this or like coverage.

(11) Charges for consulting with Covered Persons by telephone, facsimile, electronic mail systems or other consultation or medical management service not involving

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direct (face-to-face) care with the Covered Person except as otherwise described in this Contract.

(12) Surcharges for furnishing and/or receiving medical records and reports.

(13) Charges for doing research with Providers not directly responsible for your care.

(14) Charges that are not documented in Provider records.

(15) Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.

(16) Administrative or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

(18) Services prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

(19) Completion of claim forms or charges for medical records or reports unless otherwise required by law.

(20) Missed or canceled appointments.

(21) Mileage, lodging and meals costs, and other travel related expenses, except as authorized by us or specifically stated as a Covered Service in this Contract.

(22) Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.

(23) Services incurred prior to the Effective Date.

(24) Services incurred after the termination date of this coverage except as specified elsewhere in this Contract.

(25) For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Complications directly related to Cosmetic Services treatment or surgery, as determined by us, are not covered. This exclusion applies even if the original Cosmetic Services treatment or surgery was performed while the Covered Person was covered by another carrier/self-funded

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plan prior to coverage under this Contract. "Directly related" means that the treatment or surgery occurred as a direct result of the Cosmetic Services treatment or surgery and would not have taken place in the absence of the Cosmetic Services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

(26) Custodial Care, convalescent care or rest cures.

(27) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

(28) Services provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

(29) Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

(30) Services or care provided or billed by a school, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(31) Wilderness camps.

(32) For routine foot care (including the cutting or removal of corns and calluses), Nail trimming, cutting or debriding, Hygienic and preventive maintenance foot care, including but not limited to 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.

(33) Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

(34) Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to the following.

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

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(35) 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.

(36) Dental implants.

(37) Dental braces.

(38) Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following.

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer or cleft palate.

(39) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

(40) Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

(41) Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by us, are not covered. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(42) Marital counseling.

(43) Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

(44) Vision orthotic training.

(45) Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.

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(46) Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

(47) Services to reverse voluntarily induced sterility.

(48) Diagnostic testing or treatment related to infertility.

(49) Personal hygiene, environmental control, or convenience items including but not limited to the following.

- Air conditioners, humidifiers, air purifiers.
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals.
- Charges for non-medical self-care except as otherwise stated.
- Purchase or rental of supplies for common household use, such as water purifiers.
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds.
- Infant helmets to treat positional plagiocephaly.
- Safety helmets for Covered Persons with neuromuscular diseases.
- Sports helmets.

(50) Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

(51) Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by us, or as otherwise described in this Contract.

(52) Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.

(53) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

(54) For self-help training and other forms of non-medical self-care, except as otherwise provided in this Contract.

(55) Examinations relating to research screenings.

(56) Stand-by charges of a Provider.

(57) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

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(58) Services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

(59) Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Contract.

(60) Manipulation Therapy services rendered in the home as part of Home Care Services.

(61) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. This Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

(62) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

(63) Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

(64) Any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(65) Surgical treatment of gynecomastia.

(66) Treatment of hyperhidrosis (excessive sweating).

(67) Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by us through Precertification.

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(68) Complications directly related to a service or treatment that is a Non-Covered Service under this Contract because it was determined by us to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

(69) Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

(70) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

(71) Treatment of telangiectatic dermal veins (spider veins) by any method.

(72) Reconstructive services except as specifically stated in this Contract or as required by law.

(73) Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

(74) For non-preventive medical nutritional therapy.

(75) Abortions that are not Therapeutic Abortions.

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C. Experimental/Investigative Health Care Services Exclusion. We do not provide coverage for any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be Experimental/ Investigative.

(1) 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.

(a) 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 granted.

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(b) Has been determined by the FDA to be contraindicated for the specific use.

(c) Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

(e) 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.

(2) Any Health Care Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by us. In determining whether a Health Care Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

(a) The scientific evidence is conclusory concerning the effect of the Health Care Service on health outcomes.

(b) The evidence demonstrates the Health Care Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects.

(c) The evidence demonstrates the Health Care Service has been shown to be as beneficial for the total population for whom the Health Care Service might be proposed as any established alternatives.

(d) The evidence demonstrates the Health Care Service has been shown to improve the net health outcomes of the total population for whom the Health Care Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(3) Off-Label Drug Treatment. Coverage for a drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

(a) The drug is recognized for treatment of the indication in at least one standard reference compendium.

(b) The drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have

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been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the drug's use to be contraindicated or the drug has not been approved by the FDA for any indication.

(4) The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

(a) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.

(b) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.

(c) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Documents of an IRB or other similar body performing substantially the same function.

(e) Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(f) Medical records.

(g) The opinions of consulting Providers and other experts in the field.

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ARTICLE 6. OBTAINING COVERED SERVICES

A. Participating Providers.

(1) Unless otherwise specifically provided in this Contract, in order to receive Benefits under this Contract, a Covered Person must receive Covered Services from a Participating Provider.

(2) The Covered Person is responsible for verifying that a Provider is a Participating Provider. A list of Participating Providers is available online at [insert website] or by calling us at [toll free number].

B. Non-Participating Providers. Health Care Services received from Non-Participating Providers are Non-Covered Services except for the following circumstances.

(1) Emergency Health Care Services.

(a) If we determine that the Health Care Services were not an Emergency, the Health Care Services are Non-Covered Services and you will be responsible for costs associated with the Health Care Services.

(b) Subsequent follow up care by a Non-Participating Provider after the condition is no longer an Emergency is a Non-Covered Service unless specifically authorized by us.

(c) If a Covered Person is hospitalized in a Non-Participating Hospital due to an Emergency, you or the Provider must notify us within 48 hours of the admission. A continued stay after the condition is stabilized and is no longer an Emergency requires our written authorization. We may elect to transfer the Covered Person to a Participating Hospital once it is medically appropriate to do so.

(2) Non-emergency Medically Necessary Health Care Services that cannot be provided by a Participating Provider and for which the Covered Person has obtained a Referral from his/her Primary Care Physician.

(3) Maternity services for a Covered Person who was in her second or third trimester of pregnancy as of her Effective Date as provided in Article 3 Section K.

(4) When our agreement with a Participating Provider terminates, upon your written request, [you] [the Covered Person] may continue to receive Covered Services from the Provider for the following time periods.

(a) Up to sixty (60) days.

(b) In the case of Covered Person who is pregnant and in the third trimester of pregnancy, you may continue to receive Covered Services through the term of the pregnancy.

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(c) For a Covered Person who is hospitalized until the Covered Person is discharged from Inpatient status.

C. Primary Care Physician.

(1) You must designate a Primary Care Physician for each Covered Person. If you do not select a Primary Care Physician we will assign one.

(2) The Covered Person's Primary Care Physician will be responsible for coordinating Covered Services and making referrals to other Participating Providers. A Covered Person does not need a referral from his/her Primary Care Physician for obstetrical or gynecological treatment from a Participating Provider. A Covered Person may seek care directly from an obstetrician or gynecologist that is a Participating Provider. For all other Providers, the Covered Person must obtain a referral from his/her Primary Care Physician to obtain benefits for Covered Services under this Contract.

(3) You may change the selection of a Primary care Physician no more frequently than once each month. A Covered Person may change his/her Primary Care Physician by submitting a written request, online at [insert website address], or by contacting us at the number shown on your Identification Card. A change in Primary Care Physician selection will be effective no later than thirty (30) days from the date we receive a request.

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ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES.

This Article 7 sets forth the procedures for requesting approvals for Covered Services from us as well as general Grievance procedures. In processing claims, we review requests for Precertification, Predetermination, and Post Service Clinical Claims Review to determine whether provided or proposed to be provided Health Care Services are Covered Services. Health Care Services must be Medically Necessary for Health Care Services to be considered Covered Services.

A. Covered Service Review Requests.

(1) Types of Covered Service Review Requests.

(a) Precertification – 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.

(b) Predetermination – An optional, voluntary prior or concurrent request for a benefit coverage determination for a Health Care Service. We will review [your] [this] Contract to determine if there is an Exclusion for the service or treatment requested. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service or treatment meets our definition of Medical Necessity, or if it is Experimental/Investigative as that term is defined in this Contract.

(c) Post Service Clinical Claims Review – A retrospective review (Post-Service) for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Precertification and did not undergo a Predetermination review. Post Service Clinical Claims Reviews are done for Health Care Services for which we have a related clinical coverage guideline and are typically initiated by us.

(2) Most Participating Providers know which Health Care Services require Precertification and will get Precertification or ask for Predetermination from us as needed. [Your] [The Covered Person's] Primary Care Physician and all other Participating Providers have received information from us on the procedures for requesting approvals for Covered Services and are responsible for meeting the requirements under such procedures. Generally, the Participating Provider ordering the service, treatment or admission will contact us to ask for Precertification or Predetermination reviews ("Requesting Provider"). We will work directly with [your] [the] Requesting Provider regarding such review requests; however, [your] [the Covered Person's] Designated Representative may act on [your] [the Covered Person's] behalf throughout the review process.

(3) We will utilize our clinical coverage guidelines, including internally developed guidelines, procedures, and preventative care clinical coverage guidelines, to help us determine whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions Identified

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as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

(4) [You are] [The Covered Person is] entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact us at [toll free number].

B. Review Request Categories.

(1) Urgent Care – A request for Precertification or Predetermination that in the view of [your] [the] attending Provider, or any physician with knowledge of [your] [the Covered Person's] medical condition, could seriously jeopardize [your] [the Covered Person's] life or health or [your] [the Covered Person's] ability to regain maximum function, or would subject [you] [the Covered Person] to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Urgent Care Claim.

(2) Pre-Service – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

(3) Concurrent Care – A request for Precertification or Predetermination that is conducted during an ongoing course of treatment or admission. If we have approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by us of such course of treatment before the end of such period of time or number of treatments shall constitute a benefit determination adverse to [you][the Covered Person]. We will notify [you] [the Covered Person] sufficiently in advance of the reduction or termination to allow [you] [the Covered Person] to appeal and obtain a determination before the benefit is reduced or terminated.

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(4) Post-Service – A request for approval that is made after the service, treatment or admission has occurred. Post-Service review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

C. Benefit Decision and Notice Requirements.

(1) We will resolve benefit review requests according to the timeframes listed in the table below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws.

Request Categories	**Timeframe Requirement for Benefit Decisions and Notification**
Pre-Service Claim	15 calendar days from receipt of request
Pre-Service Urgent Care Claim	72 hours from receipt of request

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Concurrent Care Claim	15 calendar days from receipt of request
Concurrent Urgent Care Claim	24 hours from receipt of request
Post-Service Claim	20 business days from receipt of request

D. Timeframe Extensions for Benefit Decisions and Notifications.

(1) Post-Service and Pre-Service Claims. If we are unable to complete our review due to circumstances beyond our control, we will notify [you, your] [the Covered Person, the Covered Person's] Designated Representative, and the Requesting Provider in writing within:

(a) Fourteen (14) days after our receipt of a Pre-Service claim review request, and

(b) Nineteen (19) days after our receipt of a Post-Service claim review request.

The written notice will include the reason for the delay, a list of any applicable additional information that we need from [you] [the Covered Person] in order to complete our review and a revised timeframe for the resolution. If the reason for the delay is because [your] [the Covered Person's] review request lacked sufficient information to complete our review of [your] [the Covered Person's] request, [you, your] [the Covered Person, the Covered Person's] Designated Representative and Requesting Provider will have forty-five (45) days from receiving our notice of delay to provide the necessary information. We will notify [you, your] [the Covered Person, the Covered Person's] Designated Representative and the Requesting Provider of our decision within not more than ten (10) days after notifying [you, your] [the Covered Person, the Covered Person's] Designated Representative and Requesting Provider of the reason for our delay or of our receipt of the necessary information or of the end of the period afforded to [you] [the Covered Person] to supply the necessary information, as applicable. If we do not get the specific information we need or if the information is not complete by the timeframe provided to [you] [the Covered Person], we will make a decision based upon the information we have.

(2) Urgent Care Claims. If [you fail] [the Covered Person fails] to provide us with sufficient information to review [your] [the Covered Person's] Urgent Care Claim review request, we will notify [you] [the Covered Person] as soon as possible, but not later than twenty-four (24) hours after our receipt of the claim, of the specific information necessary to complete our review. [You] [The Covered Person] will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. We will notify [you, your] [the Covered Person, the Covered Person's] Designated Representative and Requesting Provider of our decision as soon as possible, but in no case later than forty-eight (48) hours of the earlier of the following:

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(a) our receipt of the necessary information, or

(b) the end of the period afforded to [you] [the Covered Person] to supply the necessary information.

If we do not get the specific information we need or if the information is not complete by the timeframe provided to [you] [the Covered Person], we will make a decision based upon the information we have.

E. Denial of Experimental Treatment.

(1) If we deny coverage for a treatment, procedure, drug or device on the grounds that the treatment, procedure, drug or device is experimental, we will provide [you] [the Covered Person] with a written explanation that includes the following information:

(a) The basis for the denial.

(b) [Your] [The Covered Person's] right to Appeal our decision.

(c) Our telephone number that [you] [the Covered Person] may contact for assistance in initiating an Appeal of our decision.

(2) If [your] [the Covered Person's] health situation is life threatening or is an emergency, [you are] [the Covered Person is] entitled to a review of our decision to deny coverage on the grounds that the treatment, procedure, drug or device is experimental that takes not more than seventy-two (72) hours.

F. What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(1) Availability, delivery, appropriateness, or quality of health care services.

(2) Handling or payment of claims for health care services.

(3) Matters pertaining to the contractual relationship between you and us.

G. Who May File.

(1) You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

(2) If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

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H. How a Grievance May Be Filed.

(1) You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, Toll Free Number and Fax]

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(2) A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

I. No Retaliation. Neither [you nor your] [the Covered Person's] Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 7.

J. Grievance Procedure.

(1) Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

(2) Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

(3) Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

(4) Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

(5) Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

K. Appeals Procedure.

(1) Right to an Appeal.

(a) If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

(b) You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

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(c) The Appeal may be expressed orally or in writing by contacting us at the address and phone number provided below.

[Address, Toll Free Number and Fax]

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(d) We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

(2) Appeal Panel.

(a) We will appoint a panel of qualified individuals to resolve your Appeal (the "Appeal Panel"). The Appeal Panel will resolve your Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

(b) The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date and place during normal business hours for the Appeal Panel to meet to discuss your Appeal. You will be given seventy-two (72) hours advance notice of the date and time of the meeting.

(c) You or Your Designated Representative may:

(a) appear in person before the Appeal Panel; or

(b) communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

(d) You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

(e) To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

(f) The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

(g) If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:

(a) Has knowledge in the medical condition and Health Care Service;

(b) Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and

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(c) Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with you or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.

(3) Appeal Decision and Notice of Decision.

(a) The Appeal Panel's decision regarding your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

(b) The Appeal Panel will resolve Appeals according to the timeframes listed in the table below.

Appeal Categories	**Timeframe Requirement for Appeal Decisions and Notification**
Appeal of a Pre-Service Claim Decision	30 calendar days from our receipt of the Appeal
Appeal of a Pre-Service Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Concurrent Care Claim Decision	15 calendar days from our receipt of the Appeal
Appeal of a Concurrent Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Post-Service Claim Decision	45 calendar days from our receipt of the Appeal

(c) We shall notify [you] [the Covered Person] or [your] [the Covered Person's] Designated Representative of our decision in writing regarding [your] [the] Appeal within five (5) business days after we complete our investigation.

(4) Expedited Review of Internal Appeals.

(a) An Expedited Review of an internal Appeal may be initiated orally, in writing or by other reasonable means available to [you, your] [the Covered Person, the Covered Person's] Designated Representative or [your] [the Covered Person's] Provider.

(b) Expedited Review is available only if [your] [the Covered Person's] attending Provider believes that, based upon [your] [the Covered Person's] medical condition, our standard internal Appeal procedure

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could seriously jeopardize [your] [the Covered Person's] life or health or [your] [the Covered Person's] ability to regain maximum function, or could subject [you] [the Covered Person] to severe pain that cannot be adequately managed.

(c) Appeals of Urgent Care Claim decisions are referred directly to our Expedited Review procedure for investigation and resolution.

(d) We will complete our Expedited Review of [your] [the] Appeal as soon as possible given the medical exigencies but no later than within 72 hours after our receipt of [your] [the Covered Person] request for Appeal.

(e) We will communicate our decision regarding [your] [the] Appeal by telephone to [you, your] [the Covered Person, the Covered Person's] Designated Representative, and [your] [the Covered Person's] attending Provider. We will also provide written notice of our decision to [you, your] [the Covered Person, the Covered Person's] Designated Representative and [your] [the Covered Person's] attending Provider.

(f) An Expedited Review of Concurrent Urgent Care Claims and Pre-Service Urgent Care Claims may occur at the same time as an External Review (as described below).

L. External Review.

(1) [You] [The Covered Person] or [your] [the Covered Person's] Designated Representative may seek External Review if our decision regarding [your] [the Covered Person's] Appeal upheld a decision that was adverse to you regarding any of the following.

(a) A Medically Necessary service.

(b) A utilization review decision.

(c) A determination that a proposed service is Experimental/Investigational.

(d) A decision to rescind [your] [the Covered Person's] Contract.

If [your] [the Covered Person's] Appeal did not involve one of the above adverse decisions, [you are] [the Covered Person is] not entitled to an External Review.

(2) If [you have] [the Covered Person has] the right to an External Review under Medicare (42 U.S.C. 1395, et seq.) [you] [the Covered Person] may not request an External Review of our Appeals decision under the procedures outlined in this Contract.

(3) If [your] [the Covered Person's] situation qualifies, [you] [the Covered Person] or [your] [the Covered Person's] Designated Representative must file a written request for an External Review with us within 120 days after [you receive] [the Covered Person receives] notice of our internal response to the Appeal.

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(4) Independent Review Organization (IRO).

(a) If an External Review is requested, we will forward all information related to [your] [the Covered Person's] External Review to an IRO selected from the list of IROs that are certified by the Indiana Department of Insurance.

(b) The IRO will make a determination to uphold or reverse our Appeal decision within seventy-two (72) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within fifteen (15) business days if the condition does not involve an Urgent Care Claim.

(c) The IRO will notify [you and your] [the Covered Person and the Covered Person's] Designated Representative of its decision within twenty-four (24) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within seventy-two (72) hours if the review does not involve an Urgent Care Claim.

(d) If the IRO decision reverses our Appeals decision, we will notify [you, your] [the Covered Person, the Covered Person's] Designated Representative or Provider in writing of the steps we will take to comply with the IRO's decision.

M. Important Contact Information and Notice to Covered Persons.

(1) Questions regarding [your] [the Covered Person's] coverage should be directed to: Indiana University Health Plans; [toll free number]

(2) If [you] [the Covered Person] (a) [need] [needs] the assistance of the governmental agency that regulates insurance; or (b) [have] [has] a complaint [you have] [the Covered Person has] been unable to resolve with us [you] [the Covered Person] may contact the Department of Insurance by mail, telephone or email:

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

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

(3) Complaints can also be filed electronically at www.in.gov/idoi.The review procedures described in this Article 7 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

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ARTICLE 8. PAYMENT FOR COVERED SERVICES

A. How to Obtain Benefits.

(1) Whenever [you receive] [the Covered Person receives] Health Care Services, [you] [the Covered Person] must provide the Provider with a copy of [your] [the Covered Person's] Identification Card.

(2) When [you receive] [the Covered Person receives] Covered Services from a Participating Provider you are not required to file a claim. Since no claim filing is required, you are not required to follow the procedures outlined in Section C of this Article 8.

B. Who Receives Payment Under This Contract.

(1) We pay Benefits for [your] [the Covered Person's] Covered Services directly to a Participating Provider.

(2) [If you receive] [If the Covered Person receives] Covered Services from a Non-Participating Provider as provided in Article 6 Section B, we will pay Benefits to the Non-Participating Provider, unless you agreed to make payment to the Non-Participating Provider and are entitled to reimbursement for such payment.

C. Payment for Covered Services received from Non-Participating Providers.

(1) Time to File Claims. For Covered Services received from a Non-Participating Provider, written notice of a claim must be given to us, by you or the Non-Participating Provider, within thirty (30) days of the date the Covered Services began. Failure to furnish the claim within thirty (30) days will not invalidate or reduce any claim if submission within thirty (30) days was not reasonably possible, so long as the claim is submitted within a reasonable time.

(2) Claim Forms. We shall provide forms to you for filing Proof of Loss within fifteen (15) days of notice of any claim. If you do not receive the forms within fifteen (15) days, written notice of services rendered may be submitted to us without the claim form. Claim forms are available on our website at [website address].

(3) Proof of Loss. Proof of loss under this Contract must be furnished to us within ninety (90) days after the loss. Failure to furnish the claim within ninety (90) days will not invalidate or reduce any claim if submission within ninety (90) days after the loss was not reasonably possible, so long as the claim is submitted within one (1) year after the time required under this Contract unless you were legally incapacitated.

(4) Address. All correspondence regarding claims should be sent to us at:

Indiana University Health Plans
[Address]
[City/state/zip]
[Fax]

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(5) Amount of Payment. Payment for Health Care Services received from a Non-Participating Provider will be the lesser of the following amounts.

(a) The usual, customary and reasonable charge for the Health Care Service;

(b) An amount agreed upon by us and the Non-Participating Provider.

D. Clean Claims.

(1) A clean claim is a claim submitted by a Provider for payment that has no defect. We shall pay or deny each clean claim as follows.

(a) If the claim is filed electronically, within thirty (30) days after the date we receive the claim.

(b) If the claim is filed on paper, within forty-five (45) days after the date we receive the claim.

(2) If we fail to pay or deny a clean claim in the time frames set forth above and subsequently pay the claim, we will pay the Provider that submitted the claim allowable interest in accordance with Indiana Code § 27-8-5.7-6.

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ARTICLE 9. COORDINATION OF BENEFITS

This Article applies only if you also have other health benefits coverage with another Plan. The Definitions contained in this Article apply throughout this Article 9 but do not apply to the rest of the Contract.

A. When you have other health benefits. In the event that you are covered by two health insurance contracts, plans or policies ("Plans") providing similar benefits and you receive a Health Care Service that would be covered by both Plans, we will coordinate benefit payments with any payment made under the other Plan. One company will pay its full benefit as the Primary Plan. The other company will pay Secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments.

B. Definitions.

(1) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the Plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(2) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

(3) "Closed Panel Plan" means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in the case of emergency or referral by a panel Covered Person.

(4) "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(5) "Plan" means any of the following that provides benefits or services for medical treatment:

(a) Any group or blanket insurance contract, plan or contract, except that blanket school accident coverage or such coverage offered to

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substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or contract.

(b) Any self-insured or noninsured Plan or any other Plan arranged through an employer, trustee, union, employer organization or employee benefit organization.

(c) Any coverage under governmental programs or any coverage required to be provided by any statute. However, Medicaid and any Plan whose benefits are, by law, excess to those of any private insurance plan or other nongovernmental plan shall not be considered health insurance policies.

(d) Group or nongroup coverage through Closed Panel Plans or group type contracts.

(e) Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional "fault" type contracts.

(6) "Primary" or "Primary Plan" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If the Plan is Primary to another Plan, the Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(7) "Secondary" or "Secondary Plan" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If the Plan is Secondary to another Plan, the Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

C. Rules To Determine Payment. When two or more Plans pay benefits, the rules for determining the order of payments are as follows:

(1) The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

(2) If the other Plan does not have a provision similar to this one, then it will be primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(3) A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. Order of Determination of Benefits Rules. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent is Primary, for example as an employee, subscriber or retiree is

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primary and the Plan that covers the person as a Dependent is Secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent; then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, subscriber or retiree is Secondary and the other Plan is Primary.

(2) Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods commencing after the Plan is given notice of the court decree.

(d) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(a) The Plan of the Custodial Parent.

(b) The Plan of the spouse of the Custodial Parent.

(c) The Plan of the non-Custodial Parent.

(d) The Plan of the spouse of the non-Custodial Parent.

(3) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is Primary. The same would hold true is a person is a Dependent of a person covered as a retiree or an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined Section (C)(1) of this Article 9.

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(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, subscriber or retiree (or as that person's Dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, subscriber or retiree longer is Primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid if it had been Primary.

E. Payment of the Benefit When This Plan is Secondary.

(1) When this Plan is Secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other Plan and this Plan do not exceed your expenses for an item of service. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by the Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

(a) Determine its obligation to pay or provide benefits under its Plan;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

(2) If there is a benefit reserve, the Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

(3) If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, Coordination of Benefits shall not apply between that Plan and other Closed Panel Plans.

F. Payments to Others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid.

G. Our Right to Recover Overpayment. In some cases, we may have made payment even though you had coverage under another Plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the

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payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other Plan. You agree to sign any document that we deem necessary to help us recover any overpayment.

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ARTICLE 10. TERMINATION OF COVERAGE

A. [**Guaranteed Renewable.** As long as [you continue] [a Covered Person continues] to be a Qualified Individual and this Contract continues to be a Qualified Health Plan, you may renew this Contract at your option without regard to the health status of you or any Covered Person.]

[Guaranteed Renewable. Coverage under this Contract is guaranteed renewable at the discretion of the Subscriber, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, as described in this Article 10. [You] [The Subscriber] may renew this Contract at [your] [the Subscriber's] option without regard to the health status of you or any Covered Person. You may renew this Contract by payment of the renewal premium by the end of the Grace Period of the premium due date, provided the following requirements are satisfied:

(1) Eligibility criteria outlined in Article 2 continues to be met.

(2) There are no fraudulent or intentional misrepresentations on the application or under the terms of this Contract.

(3) Coverage has not been terminated by us under the terms of this Contract.]

B. **Termination.** We may terminate this Contract or coverage of a Covered Person for the following reasons.

(1) [You are] [The Covered Person is] no longer eligible for coverage [through the Indiana Marketplace].

(2) A Covered Person is no longer eligible under [the rules of the Indiana Marketplace or] the terms of this Contract.

(3) You do not pay premium and the applicable Grace Period has been exhausted.

(4) We receive a request from you to terminate the Contract.

(5) You [commit] [or a Covered Person commits] an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact.

(6) [You change] [A Covered Person changes] coverage to another [Qualified Health Plan] [health plan] during the [Indiana Marketplace] Open Enrollment Period or a Special Enrollment Period.

(7) [The Contract is no longer a Qualified Health Plan or we are decertified by the Indiana Marketplace.]

(8) You no longer reside in our Service Area.

(9) We discontinue a particular product provided that we provide you with written notice at least ninety (90) days before the date the product will be discontinued, we offer you the option to purchase any other individual contract we currently offer, and we act uniformly without regard to any health status-related factor.

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(10) We discontinue all contracts in the individual market in Indiana provided that we provide you and the Indiana Department of Insurance with written notice at least 180 days before the date of the discontinuance, we discontinue and do not renew all contracts in the individual market in the State of Indiana, and we act uniformly without regard to any health status-related factor.

(11) We may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with the laws of the State of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

C. Effective Date of Termination. [Termination of this Contract automatically terminates all coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if [your] [this] Contract is in effect at the time such services are provided.]

(1) If you terminate this Contract or coverage for a Covered Person, the last day of coverage [will be on the last day of the billing period for which premium has been paid. A request for termination must be received by us in writing] [is:

(a) The termination date specified by you, if reasonable notice is provided;

(b) If you do not provide reasonable notice, fourteen (14) days after the termination is requested, or

(c) If you do not provide reasonable notice and request a termination date in less than fourteen (14) days, on a date determined by us if we are able to implement termination in fewer than fourteen (14) days.]

(2) [If newly eligible for Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.]

(3) [If [you] [all Covered Persons] are no longer eligible for coverage through the Indiana Marketplace, the last day of coverage is the last day of the month following the date notice is sent to us by the Indiana Marketplace, unless you request an earlier termination effective date.] [If you move outside of the Service Area, the last day of coverage for you and all of your Dependents will be at the end of the billing period that contains the date you no longer resided in the Service Area.]

(4) [If a Covered Person is no longer eligible for coverage under the rules of the Indiana Marketplace or the terms of this Contact, the last day of coverage is the last day of the month following the date the Covered Person loses eligibility.] [If a Dependent no longer meets the definition of Dependent, the last day of coverage for the Dependent will be on the last day of the billing period in which we received notice of the Dependents loss of eligibility.]

(5) In the case of a termination for non-payment of premium and the applicable Grace Period has been exhausted, the last day of coverage [for all Covered

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Persons] will [be either the last day of the first month of the 3-month Grace Period or] the last day for which premium was paid.

(6) [In the case of a termination due to a change to another Qualified Health Plan, the last day of coverage is the day before the effective date of coverage in his or her new Qualified Health Plan.]

(7) [The day following a Covered Person's death. When a Subscriber dies, the surviving spouse, if covered under the Contract, may receive an individual contract. The surviving spouse should contact [the Indiana Marketplace] [us] to identify the process for enrollment.]

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D. Notice of Termination.

(1) We shall provide you with written notice of our intent to terminate or not renew this Contract at least sixty (60) days prior to the effective date of the termination. This notice will identify the date upon which your coverage will terminate.

(2) Our notice to the Subscriber shall be deemed as notice to all Covered Persons and is sufficient if mailed to the Subscriber's address as it appears in our records.

(3) Termination of this Contract shall not prejudice any claim for Covered Services rendered before the effective date of the termination.

E. Continuation of Coverage.

(1) If we terminate this Contract, except for a termination due to our receivership, and a Covered Person is hospitalized for a medical or surgical condition on the effective date of the termination, coverage will continue for Inpatient Covered Services. Benefits shall end on the earliest of the following dates.

(a) The date the Covered Person is discharged from the Hospital.

(b) The date the Covered Person is covered under other health coverage if that coverage covers the Inpatient Hospital services.

(c) Sixty (60) days after the date this Contract ends.

(d) The last day the required premium has been paid if the Grace Period expires and the Subscriber has not made the required payment.

(e) The date the you terminate coverage.

(2) If this Contract terminates due to our receivership, coverage will continue for the following time period:

(a) The duration of the contract period for which premiums have been paid.

(b) If a Covered Person is hospitalized on the date of our receivership for the longer of the following time periods.

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(A) The period ending when the Covered Person is discharged from the Inpatient hospitalization.

(B) The duration of the contract period for which premiums have been paid.

F. Rescission. If within two (2) years after the Effective Date of this Contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that [you] [the Subscriber] or a Covered Person did not disclose on [your] [the] application, we may rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding your newly born children within 31 days of birth), we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that [you] [the Subscriber] or a Covered Person did not disclose on the application, we may rescind coverage for the additional Dependent as of his or her original Effective Date. Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by [the Subscriber or] a Covered Person may result in termination or rescission of coverage. [You are] [The Subscriber is] responsible to pay us for the cost of previously received services based on the Allowed Amount for such services, less any Copayments/Coinsurance paid or Premium paid for such services.

This Contract may also be terminated if [you] [the Subscriber or a Covered Person] knowingly [participate] [participates] in or permit fraud of deception by any Provider, vendor or any other person associated with this Contract. Termination for any act, practice or omission that constituted fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give [you] [the Subscriber] at least thirty (30) days written notice prior to the rescission of this Contract.

G. Reinstatement. If [your] [this] Contract was terminated for non-payment of premium, you may request reinstatement of the Contract from [the Indiana Marketplace] [us] within 30 days of the effective date of the termination. You must remit all premium that was due for the coverage upon reinstatement. Upon [notice from the Indiana Marketplace and] receipt of the outstanding premium, we will reinstate coverage as of the effective date of the termination.

H. [**Certification of Prior Creditable Coverage If Required by Law.** If [your] [this] coverage is terminated, [you and your Dependents] [all Covered Persons] will receive certification from us showing that [you] [they] were covered under this Contract. [You] [A Covered Person] may need this certification document in order to purchase[, for yourself and/or your family,] other health coverage. Certifications may be requested within twenty-four (24) months of losing coverage.

[You] [A Covered Person] may also request certification be provided to [you] [he or she] at any other time, even if [you have] [he or she has] not lost your coverage under this Contract. If [you have] [a Covered Person has] any other questions regarding certification of creditable coverage, contact the Customer Service telephone number on the back of your Identification Card.]

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ARTICLE 11. GENERAL PROVISIONS

A. **Entire Contract.** This Contract, the Schedule of Benefits, and any application, rider or amendment(s) make up the entire agreement between you and us as of the Effective Date and supersede all other agreements. All statements made by you shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce coverage under this Contract or be used in defense of a legal action unless it is contained in the application.

B. **No Assignment.** The benefits provided under this Contract are for [your and your enrolled Dependents'] [the] personal benefit [of all Covered Persons]. You may not assign any of [your] [these] rights to coverage. Any attempt by you to assign this Contract to any third party is void. Provided, however, that subject to our right to disapprove, you may assign your right to reimbursement for Covered Services to the Provider who provided such Covered Services.

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C. **Notice.** Any notice that we give to you under this Contract will be mailed to your address as it appears on our records. Our notice to the Subscriber is deemed notice to all [enrolled Dependents]. Notice is deemed delivered three (3) calendar days after its deposit in the United State Mail with first class postage prepaid unless otherwise stated in this Contract. If you have to give us any notice, it should be mailed to:

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Indiana University Health Plans, Inc.
950 North Meridian Street, Suite 200
Indianapolis, Indiana 46204

D. **Relationship Between Parties.** The relationships between us and Participating Providers are *solely* contractual relationships between a payor and independent contractors. Non-Participating Providers have no contractual relationship with us, nor are they our independent contractors. Providers are not our agents or employees. We and our employees are not employees or agents of Providers. The relationship between a Provider and any Covered Person is that of Provider and patient. The Provider is *solely* responsible for the services provided to any Covered Person.

E. **Disagreement with Recommended Treatment.** Each Covered Person enrolls in this Contract with the understanding that the Provider is responsible for determining the treatment appropriate for their care. [You] [The Covered Person] may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate Health Care Services in a manner compatible with [your] [the Covered Person's] wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice. [If you refuse] [If the Covered Person refuses] to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, [you] [the Covered Person] will be so advised. In such case, the Provider and we, as applicable, may determine that neither this Contract nor the Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of this Contract for the condition under treatment or any complications thereof.

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F. **Your Medical Records.** As a condition precedent to the approval of claims hereunder, each Covered Person authorizes and directs any Provider that furnishes benefits hereunder to make available to us information relating to all Health Care Services, copies thereof and other records as needed by us for purposes of administering this Contract. In every case we will hold such information and records as confidential in accordance with state and federal confidentiality requirements.

G. **Second Opinion Policy.** A second opinion may be required at our discretion prior to the scheduling of certain Covered Services. We will advise you if a proposed Covered Service is subject to the second opinion policy. If so, you must consult with a second Participating Provider prior to the scheduling of the service. You must (a) contact us to obtain a list of Participating Providers who are authorized to render a second opinion, and (b) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider. You must obtain the second opinion within thirty-one (31) days of the first opinion or as soon thereafter as is reasonably possible. Second opinions we have arranged as described above are provided at no cost to you. A second opinion may also be obtained at the request of a Covered Person, subject to separate benefit restrictions and/or Copayments or Coinsurance described in this Contract.

H. **Who May Change This Contract.** This Contract may not be modified, amended or changed, except in writing, and signed by one of our officers. No employee, agent or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage or the conditions of eligibility, enrollment or participation unless in writing and signed by one of our officers. We are not bound by any verbal statements. We will provide [you] [the Subscriber] with written notice of any material modification to this Contract not later than sixty (60) days prior to the date on which such material modification will become effective.

I. **Renewal Date.** The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date for the term set forth in the Contract unless otherwise terminated by us as permitted by the Contract or by you upon thirty (30) days' prior written notice.

J. **Identification Cards.** Identification Cards are issued by us for identification only. Possession of any Identification Card confers no right to services or benefits under this Contract. To be entitled to such services or benefits the Covered Person's premiums must be paid in full at the time the Health Care Services are sought to be received. Coverage under this Contract may be terminated by us if the Covered Person allows another person to wrongfully use the Identification Cards.

K. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Contract. An example of the use of the standards is to determine whether care was Medically Necessary. These standards will not be contrary to the descriptions in this Contract. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Contract.

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L. **Non-Discrimination.** In compliance with state and federal law, we shall not discriminate on the basis of age; gender; color; race; disability; marital status; sexual preference; religious affiliation; or public assistance status. We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care. We shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew Coverage, (b) cancel coverage, (c) limit Benefits, or (d) charge a different premium. We shall not discriminate against victims of abuse in compliance with Indiana Code Sec. 27-8-24.3-1.

M. **Incontestability.** The validity of the Contract may not be contested after two (2) years, except for nonpayment of premiums or if the disputed statement is in a written instrument signed by the Subscriber. The ineligibility of [the Subscriber or] a Dependent under the Contract may be disputed at any time.

N. **Limitation of Action.** Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Contract and within three (3) years from the date the Health Care Services were received.

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O. **Examination of Covered Persons.** We may reasonably require that [you] [a Covered Person] be examined if a question or dispute about the provision of or payment for Covered Services arises. The exam will be performed by a Participating Provider acceptable to us. We will pay for the exam.

P. **Right of Recovery.** If we pay for Health Care Services that, according to the terms of the Contract, should not have been paid, we reserve the right to recover such amounts from whom they have been paid (including the Covered Person or Provider) or any other appropriate party.

Q. **Contract is not a Medicare supplement policy.** Any Covered Services that are covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled. The benefits under this Contract for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be Primary. Where Medicare is Primary, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

R. **Contract is Not Worker's Compensation Insurance.** The coverage provided under this Contract does not replace, supplement or provide a substitute for benefits to which a Covered Person is entitled under worker's compensation, occupational disease, and similar laws. The Contract does not cover Health Care Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's

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compensation, occupational disease and similar laws, even when the circumstances below are present.

(1) If the Covered Person's employer is not properly insured or self-insured under such laws.

(2) When a Covered Person refuses to use his or her employer's designated Provider.

(3) When a Covered Person has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

A Covered Person must contact his employer or its worker's compensation or occupational disease insurer for the provision or payment of such Health Care Services.

S. General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within our control we will pay benefits for Covered Services as provided in this Contract to the extent that facilities and personnel are then available, and we shall have no liability or obligation for delay or failure to provide Covered Services due to lack of available facilities or personnel.

T. Typographical or Administrative Error. Typographical or administrative errors shall not deprive a Covered Person of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

U. Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on the Effective Date shall apply. Any Contract provision which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

V. Governing Law. This Contract will be subject to the laws of the state of Indiana.

W. Severability. In the event that any provision in the Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

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[Schedule of Benefits]

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PAGE

ARTICLE 1. DEFINITIONS 1

ARTICLE 2. ELIGIBILITY AND ENROLLMENT 9

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS 16

ARTICLE 4. COVERED SERVICES 19

ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS 54

ARTICLE 6. OBTAINING COVERED SERVICES 63

ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES 65

ARTICLE 8. PAYMENT FOR COVERED SERVICES 75

ARTICLE 9. COORDINATION OF BENEFITS 77

ARTICLE 10. TERMINATION OF COVERAGE 82

ARTICLE 11. GENERAL PROVISIONS 86

2015 IUHP Indiana Individual On- and Off-Exchange Rate Filing
SERFF Tracking Number: IUHP-129535085
IDOI Objection Letter Date: 07/07/2014
Submitted Date: 07/07/2014 10:14 AM
Response Date: 07/14/2014

1. **The factor for the impact of transitional policies seems high. At this point, we expect less than 20% of the individual market to offer transitional policies.**

   As we discussed, our response to Item 1 of the IDOI Objection Letter dated 5/27/2014 noted that the morbidity adjustment of 6.1% reflects differences in morbidity between the Individual and Group markets (since manual rates were based on Commercial experience), health status of the currently uninsured expected to enroll in 2015, and the impact of transitional ("grandmothered") policies. We estimate that the impact relating to transitional policies is less than 1 %.

2. **In Exhibit I Notes, you show that the 1.0192 = 1 + [((310.60 x 2%)-0.24)/310.60], I may have missed it, but where does the 310.60 come from?**

   As we discussed, the $310.60 may be found in row 3 of Exhibit I contained in our response to Item 1 of the IDOI Objection Letter dated 5/27/2014.

3. **As a part of the plan adjusted index rate, the age calibration should be used as calculated and not rounded to the near age. Please revise the 1.706 with 1.685.**

   As we discussed, the IDOI has given verbal approval to submit a rate filing amendment with a revised pent up demand assumption of 3.0% and a revised assumption of 2.0% for the ACA issuer fee. We will include this change as well once all remaining issues have been resolved to the satisfaction of the IDOI.

4. **The percentage of tobacco users seems low compared to the population percentage of tobacco users in the state.**

   As we discussed, we believe that 5-10% of enrollees will self-report as tobacco users given the minimal penalties for not reporting tobacco use. IUHP selected 7% as their assumption.

Two files are attached-

- **IN SERFF:** this is the submission document and have attached Cat & Class info. If column G is BLANK, then that RxCUI does not count toward any benchmark (it is zero category or class designation). Those RxCUIs were not counted in the tier counts. This file was used to created the other file.
- **HIX IN Count by Tiers:** this is the number of RxCUIs by tier for each category and class. The RXCUIs with blank Cat & Class info are found listed as OTHER on line 164 of this file with unique RXCUIs by tier broken out. Remember these 'OTHER' RXCUIs , since they do not have a Cat & Class do not count toward benchmark. On the second tab labeled OTHER RXCUIs you will see each unique RXCUI by each tier as reference only.

Keep in mind:

- An RxCUI can be classified in more than one Cat and Class. Therefore, the tier count will have a larger RxCUI count than the actual number of counted RxCUIs on the submission file
- Not counted RxCUIs are not included in the totals on lines 162. There are 1506 UNIQUE RxCUIs that do not have a cat/class and are summarized by tier in row 164 as noted above.

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/13/2014		Form	IU Health Plans Individual Product	06/19/2014	IU Health Plans - Adult and Child Only Combined Policy _clean_06122014.pdf
06/13/2014		Form	IU Health Plans Individual Product	06/19/2014	
06/05/2014		Form	IU Health Plans Individual Product	06/13/2014	IU Health Plans - Variable Contract - CHILD _clean_.pdf (Superceded)
06/05/2014		Form	IU Health Plans Individual Product	06/13/2014	IU Health Plans - Variable Contract - ADULT _clean_.pdf (Superceded)
06/02/2014		Supporting Document	Unified Rate Review Template	08/01/2014	IU Health Plans_plan_management_data_templates_unified_5.28.2014.xlsm (Superceded)
06/02/2014		Rate	Actuarial Memorandum	08/01/2014	FINAL IUHP 2015 Individual Actuarial Memorandum - Medicaid Spend Down.pdf (Superceded)
06/02/2014		Supporting Document	09 SERFF Data Field Guide (Accident & Health)	08/01/2014	SERFF Data Field Guide - IUHP_5.28.2014.xls (Superceded)
05/09/2014		Supporting Document	Actuarial Memorandum and Certifications	06/02/2014	FINAL IUHP 2015 Individual Actuarial Memorandum v2.pdf (Superceded)
05/09/2014		Rate	Actuarial Memorandum	06/02/2014	FINAL IUHP 2015 Individual Actuarial Memorandum v2.pdf (Superceded)
05/08/2014		Form	IU Health Plans Schedule of Benefits - Silver HSA 73	08/01/2014	IU Health Plans Schedule of Benefits - Silver HSA - CSR 73_5.9.14.pdf (Superceded)
05/08/2014		Form	IU Health Plans Schedule of Benefits - Silver Value 73	08/01/2014	IU Health Plans Schedule of Benefits - Silver Value - CSR 73_5.9.14.pdf (Superceded)
05/08/2014		Form	IU Health Plans Schedule of Benefits - Silver Enhanced 73	06/04/2014	IU Health Plans Schedule of Benefits - Silver Enhanced - CSR 73_5.9.14.pdf (Superceded)

SERFF Tracking #: IUHP-129535085 **State Tracking #:** 13164.1-INDIV-POLICY (01/2015) **Company Tracking #:**

State: Indiana **Filing Company:** IU Health Plans
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IU Health Plans Individual Product
Project Name/Number: Marketplace Ind 2015/

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/08/2014		Form	IU Health Plans Schedule of Benefits - Silver HSA 87	08/01/2014	IU Health Plans Schedule of Benefits - Silver HSA - CSR 87_5.9.14.pdf (Superceded)
05/08/2014		Form	IU Health Plans Schedule of Benefits - Silver Enhanced 94	08/01/2014	IU Health Plans Schedule of Benefits - Silver Enhanced - CSR 94_5.9.14.pdf (Superceded)
05/08/2014		Form	IU Health Plans Individual Product	06/13/2014	IU Health Plans - Application - ADULT_CHILD.pdf (Superceded)
05/08/2014		Rate	Actuarial Memorandum	05/09/2014	FINAL IUHP 2015 Individual Actuarial Memorandum.pdf (Superceded)
05/08/2014		Form	IU Health Plans Individual Product	06/05/2014	IU Health Plans - Variable Contract - CHILD.pdf (Superceded)
05/07/2014		Form	IU Health Plans Individual Product	06/05/2014	IU Health Plans - Variable Contract - ADULT.pdf (Superceded)
05/07/2014		Supporting Document	Actuarial Memorandum and Certifications	05/09/2014	FINAL IUHP 2015 Individual Actuarial Memorandum.pdf (Superceded)
05/07/2014		Supporting Document	Unified Rate Review Template	06/02/2014	
05/07/2014		Supporting Document	09 SERFF Data Field Guide (Accident & Health)	06/02/2014	

SERFF Tracking #:	IUHP-129535085	**State Tracking #:**	13164.1-INDIV-POLICY (01/2015)	**Company Tracking #:**	

State:	Indiana	**Filing Company:**	IU Health Plans
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO		
Product Name:	IU Health Plans Individual Product		
Project Name/Number:	Marketplace Ind 2015/		

Attachment IU Health Plans_plan_management_data_templates_unified_5.28.2014.xlsm is not a PDF document and cannot be reproduced here.

Attachment SERFF Data Field Guide - IUHP_5.28.2014.xls is not a PDF document and cannot be reproduced here.

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CHILD-ONLY CONTRACT
[Issued through the Indiana Marketplace]
(herein called the "Contract")

[Product Name]

Issued by:

Indiana University Health Plans, Inc.
an Indiana domestic health maintenance organization
950 North Meridian Street
Indianapolis, Indiana 46204

[This coverage is issued through the Indiana Marketplace to provide coverage for a Dependent.] This Contract sets forth in detail the rights and obligations of the Subscriber. It is important that you **read this Contract carefully.** This Contract provides coverage only for enrolled Dependents. This Contract includes limitations and exclusions. You should familiarize yourself with its terms and conditions before receiving Health Care Services. Capitalized terms have the meaning set forth in the Definitions sections.

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, you may return it to us or the agent who sold it to you within 10 days after your receipt. Your premium will be refunded and this Contract with be void from its start. Any Health Care Services received during this 10-day period are solely your responsibility.

Benefits under this Contract may vary depending on other medical expense insurance you may have.

If you have questions related to the health insurance coverage provided under this Contract, you may contact us at [toll free number] [or the Indiana Marketplace at www.healthcare.gov or [toll free number].]

[signature]
President

[**DISCLAIMER:** The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace.]

TABLE OF CONTENTS

PAGE

ARTICLE 1. DEFINITIONS 1
ARTICLE 2. ELIGIBILITY AND ENROLLMENT. 9
ARTICLE 3. YOUR FINANCIAL OBLIGATIONS 16
ARTICLE 4. COVERED SERVICES 19
ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS 54
ARTICLE 6. OBTAINING COVERED SERVICES 63
ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES 65
ARTICLE 8. PAYMENT FOR COVERED SERVICES 74
ARTICLE 9. COORDINATION OF BENEFITS 76
ARTICLE 10. TERMINATION OF COVERAGE 81
ARTICLE 11. GENERAL PROVISIONS 85

ARTICLE 1. DEFINITIONS

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, Dependent or Covered Person, either collectively or individually as appropriate to the reference.]

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc.. The term “you” refers to you, the Subscriber, in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber, or the Dependent or Covered Person, either collectively or individually as appropriate to the reference.]

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.

Approved Clinical Trial – a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

(a) A trial that is approved or funded by one, or a combination, of the following.

(a) The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services.

(b) The United States Food and Drug Administration.

(c) The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(d) The United States Department of Veteran’s Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(e) The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).

(f) The Centers for Disease Control and Prevention.

(g) The Agency for Health Care Research and Quality.

(h) The Centers for Medicare and Medicaid Services (CMS).

(i) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks.

(j) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(k) A qualified non-governmental research entity in guidelines issued by the National Institutes of Health for center support grants.

(2) A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.

(3) A study or investigation done for drug trials which are exempt from the investigational new drug application.

For purposes of this definition, the term "life threatening condition" means any disease or condition from which death is likely unless the disease of condition is treated.

Behavioral Health – a physical or behavioral condition having an emotional or psychological origin or effect, including substance abuse. Behavioral Health Services include mental health services and substance abuse services.

Benefits – your right to payment for Covered Services under this Contract subject to the terms, conditions, limitations, and exclusions of this Contract.

Child or Children – a child of the Subscriber or Subscriber's spouse, including any of the following until the Child attains the age of 21.

- Natural child,
- Stepchild,
- Legally adopted child,
- Child placed for the purpose of adoption, or
- Child placed under legal guardianship or legal custody.

Child includes a child of any age who is incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 26 and the Subscriber principally supports the Child. Proof of the disability must be submitted to us within thirty-one (31) days of the child's 21st birthday. For two years we may require proof of the child's continuing disability and dependency at reasonable intervals. After two years, we may require proof of the child's disability and dependency no more than once per year.

Coinsurance – a percentage of the Allowed Amount that the Subscriber must pay for certain Covered Services. Coinsurance amounts are set forth in the Schedule of Benefits.

Contract – this individual contract issued by Indiana University Health Plans, Inc. which provides Benefits for Covered Services received by and enrolled Dependents. The term Contract includes the Schedule of Benefits, any application, amendments and riders.

Copayment – a fixed amount the Subscriber pays to a Provider for a Covered Service. The amount of a Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

Cosmetic Services – Health Care Services primarily intended to preserve, change or improve a Covered Person's appearance or are furnished for psychiatric or psychological reasons.

Cost Sharing – the amount you are required to pay for Covered Services. Cost Sharing can be in the form of Copayments, Coinsurance or Deductibles.

Covered Person –any Dependent who meets all applicable eligibility requirements for coverage under this Contract, is enrolled as provided in this Contract, and for whom the required premium payment has been received by us.

Covered Services – Health Care Services provided to a Covered Person performed, prescribed, directed or authorized by a Provider and for which this 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 this Contract is in force.
- Not experimental/investigative.
- Authorized in advance by us if Precertification is required under this Contract.
- Not excluded or limited by this Contract.

Deductible – the amount the Subscriber must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The amount of the Deductible is set forth in the Schedule of Benefits.

Dependent – an individual who satisfies the eligibility requirements to enroll as a Dependent as set forth in Article 2.

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 [website] 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.

Durable Medical Equipment – Medical equipment that:

- can withstand repeated use and is not disposable,
- is used to serve a medical purpose,
- is generally not useful to a person in the absence of a Sickness or injury,
- is appropriate for use in the home, and
- is the most cost-effective type of medical apparatus appropriate for the condition.

Effective Date – the date when coverage under this Contract begins.

Emergency Medical Condition or Emergency – a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent 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 woman, the health of the

woman or her unborn child) in serious jeopardy.
- Serious impairment to a person's bodily functions.
- Serious dysfunction of a bodily organ or part of a person.

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, 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, 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 woman 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 woman or the unborn child.

FDA – the United States Food and Drug Administration.

Grace Period – the time period for payment of premium set forth in Article 3 Section B.

Health Care Services – medical or health care services, whether or not covered under this 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.

Indiana Marketplace – the health benefit exchange established by the Affordable Care Act for the state of Indiana.

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

Medically Necessary – those Health Care Services that we determine to be all of the following.

(4) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the Covered Person's illness, injury or disease.

(5) Required for the direct care and treatment or management of the Covered Person's illness, injury or disease.

(6) If not provided, the Covered Person's condition would be adversely affected.

(7) Provided in accordance with generally accepted standards of medical practice.

(8) Not primarily for the convenience of the Covered Person, your family, the physician or another prescribing Provider.

(9) 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 Covered Person'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 Covered Person'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 used in this 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 – 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 this Contract.

Non-Participating Hospital – a Hospital that has not entered into a contractual agreement with us or is not otherwise engaged by us to provide Health Care Services to Covered Persons under this 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 Covered Persons under this Contract.

[**Open Enrollment Period** – the number of days each year during which individuals may enroll in a Qualified Health Plan through the Indiana Marketplace.]

[**Open Enrollment Period** – the number of days each year during which individuals may enroll for coverage under this Contract.]

Out of Pocket Maximum – the maximum amount you will pay for Covered Services in a Plan Year.

Outpatient – receipt of Health Care Services while not an Inpatient.

Participating Hospital – a Hospital 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 Covered Persons under this Contract.

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 Covered Persons under this Contract.

Plan Year – the calendar year during which this Contract is in effect. This Plan Year will be the 12 month calendar year except that if the Subscriber's Effective Date is after January 1st the Plan Year will begin on the Effective Date and end December 31st.

Precertification – 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.

Prescription Drug – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product, insulin, diabetic supplies, and syringes.

Prescription Legend Drug – A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

Primary Care Physician or 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 a Covered Person's medical care under this Contract.

Provider – a doctor, Hospital, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

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.

(1) The Health Care Service that is the subject of the Approved Clinical Trial.

(2) 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.

(3) 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.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) 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.

(6) A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.

(7) A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Qualified Health Plan – a health plan offered on the Indiana Marketplace that satisfies the requirements set forth under the Affordable Care Act (42 U.S.C. 18021(a)(1)).

[**Qualified Individual** – an individual who has been determined by the Indiana Marketplace to be eligible to enroll in a Qualified Health Plan.]

Schedule of Benefits – the part of this Contract that sets forth Cost Sharing, Out of Pocket Maximums, limitations and other information regarding a Covered Person's coverage under this Contract.

Service Area – the counties in which we are authorized to offer a qualified health plan. Our Service Area is [insert list of counties].

Sickness – a physical illness, disorder, or disease.

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.

[**Special Enrollment Periods** – enrollment periods administered by the Indiana Marketplace that occur outside of the Open Enrollment Period. Qualified Individuals and their dependents who are eligible for a Special Enrollment Period may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another during a Special Enrollment Period set for them by the Indiana Marketplace.]

[**Special Enrollment Periods** – enrollment periods administered by us that occur outside of the Open Enrollment Period.]

Spouse – the Subscriber's legal spouse.

Subscriber – an individual whose name is on the Contract and has enrolled a Dependent for coverage under this Contract. A Subscriber is the legal parent or legal guardian of the Covered Person. The Subscriber is not a Covered Person under this Contract.

Therapeutic Abortion – an abortion performed to save the life or health of the mother, or as a result of incest or rape

Urgent Care Claim – 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 a Covered Person's life, health or ability to reach and maintain maximum function.
- In the opinion of physicians familiar with a Covered Person's condition, would subject a Covered Person to severe pain that cannot be adequately managed unless we approve the Claim.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT.

[This Contract is available through the Indiana Marketplace. The Benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Indiana Marketplace to be Qualified Individuals.]

A. **The Covered Person as an Individual:** To be eligible for coverage as a Subscriber, an individual must meet the eligibility requirements listed below at the time of application and throughout the Plan Year.

(1) [Determined by the Indiana Marketplace to be a Qualified Individual for purposes of enrollment in a Qualified Health Plan.] [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective.]

(2) [Not incarcerated.] [Agree to pay the cost of the Premium that we require.]

(3) [A United States citizen or lawfully present non-citizen.] [Submit proof satisfactory to us to confirm Dependent eligibility.]

(4) To be eligible as a Dependent, the person must be the Subscriber's Child.

(5) Under age 21.

(6) A resident of the State of Indiana.

(7) Not entitled to or enrolled in Medicare or Medicaid.

(8) Not covered by any other group or individual health benefit plan.

B. [**Other Rules About Eligibility.** No one will be denied enrollment or re-enrollment in this Contract because of health status, or the existence of a pre-existing physical or mental condition.]

C. **Open Enrollment**.

(1) [Notice of Annual Open Enrollment. Each calendar year the Indiana Marketplace will provide you with a written annual open enrollment notification no earlier than September 1, and no later than September 30.]

[Notice of Annual Open Enrollment. Each calendar year we will provide you with a prior written notice of the Open Enrollment Period.]

(2) [2015 Open Enrollment Period. For this Plan Year beginning on January 1, 2015, the Open Enrollment period begins on November 15, 2014 and extends through February 15, 2015.]

(3) [Effective Dates for Coverage Selected During 2015 Open Enrollment. For this Plan Year beginning on January 1, 2015, the following Effective Dates will apply:

(a) January 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace on or before December 15, 2014.

(b) February 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from December 16, 2014 through January 15, 2015.

(c) March 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from January 16, 2015 through February 15, 2015.]

(4) [Effective Dates for Coverage Selected During Annual Open Enrollment. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if we receive the application and initial premium payment between the 1st and 15th of the month. If we receive the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st)]

D. [**Special Enrollment Period.**

(1) Special Enrollment Triggering Events. The Indiana Marketplace must allow Qualified Individuals and Dependents to enroll in a Qualified Health Plan or change from one Qualified Health Plan to another as a result of experiencing any of the following triggering events:

(a) Loss of Minimum Essential Coverage.

(b) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(c) Gaining status as a citizen, national, or lawfully present individual.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services ("HHS"), or its instrumentalities as evaluated and determined by the Indiana Marketplace. In such cases, the Indiana Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to a new service area of the Indiana Marketplace.

(h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(i) Demonstration to the Indiana Marketplace, in accordance with guidelines issued by HHS, that the Dependent meets other exceptional circumstances as the Indiana Marketplace may provide.

(j) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.)

(2) Indiana Marketplace Administration of Special Enrollments. For additional information on special enrollment triggering events and how to enroll in or change a Qualified Health Plan during a Special Enrollment Period, you should contact the Indiana Marketplace at [toll free number] or visit the Indiana Marketplace website at [www.healthcare.gov].

(3) Notice Requirement for Special Enrollments. Unless specifically stated otherwise in the applicable Indiana Marketplace rules, a person has sixty (60) days from the date of a special enrollment triggering event to select a Qualified Health Plan.

(4) Special Enrollment Effective Dates. The Effective Date for coverage obtained under this Contract during a Special Enrollment Period depends on the type of triggering event that qualified the individual and/or dependent for the Special Enrollment Period as well as the date the Indiana Marketplace received the Qualified Individual's Qualified Health Plan selection.

(a) For a Qualified Health Plan selection received from the first (1st) through the fifteenth (15th) day of any month, the Effective Date will be the first (1st) day of the following month; and

(b) For a Qualified Health Plan selection received from the sixteenth (16th) through the last day of any month, the Effective Date will be the first (1st) day of the second following month.]

D. [**Changes Affecting Eligibility and Special Enrollment Periods.**

(1) Special Enrollment Triggering Events. A Special Enrollment Period is a period during which an eligible individual who experiences certain triggering events or changes in eligibility may enroll in this Contract, outside of the Open Enrollment period.

(2) Length of Special Enrollment Period. Unless otherwise stated, an eligible individual has 60 days from the date of a triggering event to enroll an eligible individual in this Contract.

(3) Triggering Events

(a) Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, misrepresentation of a material fact or failure to pay premium.

(b) Loss of Minimum Essential Coverage due to dissolution of marriage.

(c) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Indiana Marketplace.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to new service area of the Indiana Marketplace.

(h) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.]

E. Adding New Dependents Under A Special Enrollment Period

(1) Newly Born Children. If the Subscriber has a new Dependent as a result of birth, coverage for the new Dependent is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for the new Dependent shall continue beyond the initial thirty-one (31) days, provided the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace to add the new Dependent to this Contract] [submits a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, if any[, within 60 days after the birth of the new Dependent]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days after the date of birth. The Effective Date will be the date of birth.]

If a Covered Person has a newborn child, coverage for the newborn child is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for the newborn child shall continue beyond the initial thirty-one (31) days, provided the newborn child meets the definition of Child under this Policy

and the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace] [submits a form to us] to add the Child to this Contract and we receive payment for additional applicable premium, if any. If the newborn child does not meet the definition of Child under this Policy before the end of the initial thirty-one (31) days, coverage for the newborn child will terminate upon the thirty-second (32nd) day.

(2) Adopted Children. If the Subscriber has a new Dependent as a result of adoption, coverage for the new Dependent is automatically provided from the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the Subscriber custody of the child for purposes of adoption, for up to thirty-one (31) days. Coverage for the new Dependent shall continue beyond the initial thirty-one (31) day period provided the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace to add the new Dependent to this Contract] [submits a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, in any[, within 60 days following the date of adoption or placement for adoption]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of adoption or placement of adoption.] The Effective Date will be the earlier of the date of adoption or placement of adoption.

(3) Adding a Child due to Award of Guardianship. If the Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a Child, an application to cover the Child under this Contract must be submitted to [the Indiana Marketplace] [us] within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

(4) Qualified Medical Child Support Order. If the Subscriber is required by a Qualified Child Support Order or court order, as defined by applicable state and federal law, to enroll his or her Child under this Contract, and the Child is otherwise eligible for the coverage, [the Indiana Marketplace] [we] will permit the Subscriber's Child to enroll in this Contract, and we will provide the benefits of this Contract in accordance with the applicable requirements of such court order.

A Child's coverage under this provision will not extend beyond the Dependent attaining age 26. Any claims payable under this Contract will be paid, at our discretion, to the Child or the Child's custodial parent or legal guardian, for any expenses paid by the Child, custodial parent or legal guardian. We will make information available to the Child, custodial parent or legal guardian on how to obtain benefits and submit claims to us directly.

(5) New Dependent as a Result of Marriage or Loss of Minimum Essential Coverage. If the Subscriber has a new Dependent as a result of marriage, or due to the new Dependent's loss of Minimum Essential Coverage, the Subscriber may elect to enroll the new Dependent in this Contract, provided the Subscriber [requests a Special Enrollment Period from the Indiana Marketplace to add your new Dependent to this Contract] [submits to us a form to add your new

Dependent] and we receive payment for additional applicable premium, if any[, within 60 days from the date of marriage or the loss of Minimum Essential Coverage]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of marriage or the loss of Minimum Essential Coverage.] The Effective Date will be on the first (1st) day of the month following the date of marriage or loss of Minimum Essential coverage.

(a) "Loss of Minimum Essential Coverage" includes loss of eligibility for coverage as a result of any of the following:

(a) Legal separation or divorce.

(b) Cessation of dependent status (such as reaching the maximum age to be eligible as a Dependent under this Contract).

(c) Death of an employee; termination of employment; reduction in the number of hours of employment; or any loss of eligibility for coverage after a period that is measured by any of the foregoing.

(d) Individual who no longer resides, lives or works in the service area.

(e) A situation in which a health benefit plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Termination of employer contributions.

(g) Exhaustion of COBRA continuation of coverage.

(b) "Loss of Minimum Essential Coverage" does not include termination or loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(b) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact

If the Subscriber does not enroll a new Dependent during the time periods stated above, the new Dependent will not be added to the coverage under this Contract until the next Open Enrollment Period.

F. Notification of Changes.

(1) Responsibility to Notify [the Indiana Marketplace] [Us]. The Subscriber is required to notify [the Indiana Marketplace] [us] of any changes in a Covered Person's eligibility for Benefits under this Contract. [The Indiana Marketplace] [We] must be notified of any changes in eligibility as soon as possible, but not later than thirty (30) days from the date of the change in eligibility status. This

may include changes in address, marriage, divorce, death, incarceration, change of Dependent disability or dependency status, change in Medicare or Medicaid eligibility status, etc. Notice of a change in eligibility must be provided to [the Indiana Marketplace in a form required and approved by the Indiana Marketplace] [us in writing and on a form approved by us]. Such notifications must include all information required to effectuate all necessary changes.

(2) Failure to Notify [Indiana Marketplace] [Us]. Failure to notify [the Indiana Marketplace] [us] of persons no longer eligible for coverage under this Contract will not obligate us to provide services to those no longer eligible. Our acceptance of payments for persons no longer eligible for services will not obligate us to pay for such services.

(3) Effective Date of Termination Due to Change in Eligibility. Regardless of whether we receive timely notice, a Covered Person's coverage will terminate on the [last day of the month following the date] [day] such Covered Person ceases to be eligible for coverage under this Contract. [We have the right to bill the Subscriber for the cost of any Health Care Services provided to a Covered Person during the period such Covered Person is not eligible under this Contract.] If the Subscriber thinks there are reasons coverage of the person experiencing the change should continue, the Subscriber must notify [the Indiana Marketplace] [us] of the reasons for the continuation of the coverage no later than thirty-one (31) days after the date coverage for the Dependent would otherwise terminate.

(4) [Statements and Forms. You shall complete and submit to us applications and other forms or statements we may request. You represent to the best of their knowledge and belief that all information contained in such applications, forms, questionnaires, and statements submitted to us is true, correct and complete. You understand that all rights to Benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you or a Covered Person may result in termination or rescission of coverage.]

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A. Premium

(1) The Subscriber must pay premium to us each month for coverage under this Contract. The Subscriber's premium rate is determined using the following acceptable rating factors: age, tobacco use, family size and geography.

(a) Tobacco use impacts the determination of the premium. [Upon enrollment through the Indiana Marketplace] [During the enrollment application process], the Subscriber will attest to tobacco use by his or her Dependents. If the Subscriber reports false or incorrect information about tobacco use, we may retroactively apply the appropriate tobacco rating factor to the Subscriber's premium as if the correct information had been accurately reported from the Effective Date.

(b) A Covered Person's age impacts the determination of the premium rate. If a Covered Person's age has been misstated, we will adjust the premiums to the amount premiums would have been if purchased at the correct age.

(2) The Subscriber will receive a monthly bill for your premium. The Subscriber's payment is due by the date stated in the Subscriber's bill subject to the any applicable Grace Period stated in this Contract. The Subscriber must pay the premium when it is due for coverage to continue.

(3) We reserve the right to change the premium on an annual basis. We will provide the Subscriber with thirty (30) days prior written notice of any change in the premium.

(4) The Subscriber's premium may change if Dependents are enrolled or disenrolled in the coverage under this Contract. If a premium increase is necessary, we will bill the Subscriber for the additional amount due. If this amount is not paid, this Contract will be cancelled at the end of the applicable Grace Period and the Subscriber will receive a refund of any unearned premium. If a decrease in premium is appropriate we will notify the Subscriber of the decrease and refund any excess premium to the Subscriber.

(5) If premium has been paid for any period of time after the date the Subscriber cancels this Contract, we will refund that premium to the Subscriber. The refund will be for the period of time after coverage under this Contract ends. If a Covered Person dies while this Contract is in force, we will refund any premium paid for such Covered Person for any period after the date of the Covered Person's death.

B. Grace Period

(1) [General Grace Period.] Following payment of the initial premium, a Grace Period of thirty (30) days shall be granted for the payment of any premium. This Grace Period shall not extend beyond the date this Contract terminates. During

the Grace Period this Contract shall continue in force. Any claims incurred and submitted during the Grace Period will not be considered for payment until premium is received. If premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of coverage.

(2) [Grace Period for Persons Receiving Advance Payments of the Premium Tax Credit. If the Subscriber or Covered Person is receiving advance payments of the premium tax credit and at least one full month's premium has been paid during this Plan Year, a Grace Period of three (3) consecutive months shall be granted for the payment of any premium. During this 3-month Grace Period, we shall do all of the following listed below.

(a) Pay for Covered Services during the first (1st) month of the Grace Period and may pend claims for Covered Services rendered to the Covered Person in the second and third months of the Grace Period.

(b) Notify the Department of Health and Human Services of such non-payment

(c) Notify Providers of the possibility for denied claims during the second and third months of the Grace Period.]

C. Deductible.

(1) The Deductible is the amount the Subscriber must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The Deductible is set forth in the Schedule of Benefits.

(2) Copayments do not count towards the Deductible.

D. Coinsurance

(1) Coinsurance is a percentage of the Allowed Amount that the Subscriber must pay for Covered Services. The Subscriber is responsible for payment of Coinsurance after the Subscriber has met the Deductible and until the Subscriber reaches the Out of Pocket Maximum. Coinsurance is set forth in the Schedule of Benefits.

(2) Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

E. Copayments

(1) Copayments are a fixed amount the Subscriber pays to a Provider for a Covered Service. Copayments are typically paid when the Subscriber receives the Covered Service. The amount of the Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

(2) Copayments do not apply to the Deductible. Copayments apply towards the Out of Pocket Maximum.

F. Out of Pocket Maximum

(1) The Out of Pocket Maximum is the maximum amount the Subscriber will pay for Covered Services in a Plan Year. The Out of Pocket Maximum is listed on the Schedule of Benefits.

(2) Once the Out of Pocket Maximum is reached, we will pay 100% of the Benefits for Covered Services.

(3) Copayments, Coinsurance and the Deductible apply towards the Out of Pocket Maximum.

G. Payments for Non-Covered Services. The Subscriber is responsible for payment of all expenses for Non-Covered Services.

ARTICLE 4. COVERED SERVICES

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides Benefits for the following Covered Services. Payment for Covered Services is limited by any applicable Coinsurance, Copayment, or Deductible set forth in this Contract including the Schedule of Benefits. To receive maximum Benefits for Covered Services, the terms of this Contract must be followed, including receipt of care from a Primary Care Physician and Participating Providers as well as obtaining any required Precertification.

You are responsible for all expenses incurred for Non-Covered Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

A. Ambulance Services

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

(a) From your home, scene of accident or medical Emergency to a Hospital,

(b) Between Hospitals,

(c) Between a Hospital and Skilled Nursing Facility, or

(d) From a Hospital or Skilled Nursing Facility to your home.

(2) Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

(3) Other vehicles which do not meet the definition of Ambulance Services are not Covered Services. Ambulette services are Covered Services when appropriate.

(4) Ambulance Services are a Covered Service only when Medically Necessary, except:

(a) When ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse, or

(b) When a Covered Person is required by us to move from a Non-Participating Provider to a Participating Provider.

(5) Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health.

(6) Non-Covered Services for Ambulance include but are not limited to:

(a) A trip to a physician's office or clinic,

(b) A trip to a morgue or funeral home, or

(c) Any ambulance usage for the convenience of a Covered Person, family or Provider.

B. Behavioral Health Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Covered Services include:

(a) Inpatient services. Individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

(b) Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

(c) Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health conditions. Intensive Outpatient programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient programs may offer group, DBT, individual, and family services.

(d) Outpatient Treatment, or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

(2) Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

(3) To assist you in obtaining appropriate and quality care, we will ask for a treatment plan after you have been evaluated after 10 Outpatient visits. We may discuss the goals of treatment and changes in the treatment plan, including

alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

(4) Non-Covered Services include the following.

(a) Custodial or domiciliary care.

(b) Supervised living or halfway houses.

(c) Services or care provided or billed by a residential treatment center, school, halfway house.

(d) Custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(e) Services related to non-compliance of care if the Covered Person ends treatment for substance abuse against the medical advice of the Provider.

C. Routine Care Costs as Part of a Cancer or Other Life Threatening Disease or Condition Clinical Trial

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits are available for Routine Care Costs rendered as part of an Approved Clinical Trial if the services are otherwise Covered Services under this Contract.

(2) Your Primary Care Physician must give us notice of your participation in an Approved Clinical Trial.

(2) Non-Covered Services include the following.

(a) A Health Care Service that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient.

(b) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service or investigational drug that is the subject of the clinical trial.

(c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.

(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the clinical trial.

(e) An item or drug provided by the clinical trial sponsors free of charge for any patient.

(f) A service, item, or drug that is eligible for reimbursement by a person or entity other than us, including the sponsor of the clinical trial.

D. Dental Services Related to an Injury

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient services, Physician Home Visits and Office Services, Emergency Services and Urgent Care Center Services for dental work and oral surgery are Covered Services if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Covered Person's condition.

(2) Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

(3) For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

(4) Covered Services include, but are not limited to the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations
- Prosthetic services
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia

(5) Anesthesia and Hospital charges for dental care for a Covered Person less than 19 years of age or a Covered Person who is physically or mentally disabled, are covered if the Covered Person requires dental treatment to be given in a Hospital or Outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Covered Person's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

E. Diabetic Equipment, Education and Supplies

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when ordered in writing by a physician or a podiatrist and provided by a physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

(2) Covered Services include physician prescribed equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances”, “Preventive Care Services”, and “Physician Home Visits and Office Services”.

F. Diagnostic Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services include the following.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).

- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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

(3) For Diagnostic services other than those approved to be received in a physician's office, you may be required to use a laboratory that is a Participating Provider.

(4) When Diagnostic radiology is performed in a Participating Provider's Office, no Copayment is required, however, any Coinsurance will still apply.

G. Emergency Care Services and Urgent Care Center Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit limitation. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits for treatment of an Emergency Medical Condition and Emergency screening and stabilization services without Precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions.

(2) Benefits for Emergency Care include facility costs and physician services, supplies and Prescription Drugs charged by that facility.

(3) Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Copayment or Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify us or verify that your physician has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary. If your Provider is a Non-Participating Provider, you will be financially responsible for any care we determine is not Medically Necessary.

(4) Often an urgent rather than an Emergency Medical Condition exists. An urgent medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Such medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Primary Care Physician prior to receiving care for an urgent medical problem and your Primary Care Physician

authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Care Services.

H. Home Care Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Covered Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Care Services.
- Nutritional Guidance.
- Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Health Care Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Care Services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services in the home (except for Massage, Music, and Manipulation Therapy). Home Care visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

(3) Non Covered Services include the following.

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

(4) Home infusion therapy will be paid only if you obtain Precertification. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

I. Hospice Services

For all Covered Services, see the schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit limitations. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) 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 (6) months or less, as certified by the attending physician and hospice medical director. Covered Services will continue if the Covered Person lives longer than six (6) months, provided the hospice medical director or other hospice physician recertifies that the Covered Person is terminally ill.

(2) Covered Hospice Services include the following.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Care Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

(3) Non-Covered Services include services provided by volunteers and housekeeping services.

J. Inpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Inpatient services include the following.

(a) Charges from a Hospital, Skilled Nursing Facility or other Provider for room, board and general nursing services.

(b) Ancillary services.

(c) Professional services from a physician while an Inpatient.

(2) Room, Board, and General Nursing Services include either of the following.

(a) A room with two or more beds or a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

(b) A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

(3) Ancillary (Related) Services include any of the following.

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

(4) Professional Services include the following.

- Medical care visits limited to one visit per day by any one physician.
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, and EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

(5) When a Covered Person is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

K. Maternity Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

(2) If the Covered Person is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider for the Health Care Services to be Covered Services. If the Covered Person is pregnant on her Effective Date and is in her second or third trimester of pregnancy, she may receive Benefits for Health Care Services from a Non-Participating Provider if she requests and receives written approval from us.

(3) If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance or Copayment.

(4) If Maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

(5) Coverage for the Inpatient postpartum stay for a Covered Person and her newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if both or the following are met.

(a) In the opinion of your attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the following.

- The antepartum, intrapartum, and postpartum course of the mother and infant.
- The gestational stage, birth weight, and clinical condition of the infant.
- The demonstrated ability of the mother to care for the infant after discharge.
- The availability of post discharge follow-up to verify the condition of the infant after discharge.

(b) The mother of the newborn child agrees with the recommendation for a shorter length of stay.

(6) Covered Services include at-home post-delivery care visits at your residence by a physician or nurse performed no later than 48 hours following discharge from the Hospital. Coverage for this visit includes, but is not limited to parent education, assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At your discretion, this visit may occur at the physician's office.

(7) Covered Services include the following tests and examinations given at the earliest feasible time to the newborn child for the detection of the following disorders.

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

L. Medical Supplies, Durable Medical Equipment and Appliances

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Medical and Surgical Supplies. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a physician's office, including but not limited to, Depo-Provera and Remicade. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

(a) Covered Services include the following.

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.

- Clinitest.
- Needles/syringes.
- Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not Covered Services.

(b) Non-Covered Services include the following.

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Medijectors.

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

(3) Durable Medical Equipment - The rental (or, at our option, the purchase) of Durable Medical Equipment prescribed by a Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples of Durable Medical Equipment include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price.

(a) We will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Covered Person, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is a Covered Service.

(b) Covered Services include the following.

- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pump for IV fluids and medicine.
- Glucometer.

- Tracheotomy tube.
- Cardiac, neonatal and sleep apnea monitors.
- Augmentive communication devices are Covered Services when we approve based on the Covered Person's condition.
- CPAP machines when indicated for sleep apnea.

(c) Non-Covered Services include the following.

- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats.
- Rental of equipment if the Covered Person is in a Facility that is expected to provide such equipment.
- Translift chairs.
- Treadmill exerciser.
- Tub chair used in shower.

(4) Prosthetics. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

(a) Prosthetic devices should be purchased not rented. Applicable taxes, shipping and handling are Covered Services.

(b) Covered Services include the following.

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Plan Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction

is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered Services. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be a Covered Service.

- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Plan Year).

(c) Non-Covered Services include the following.

- Dentures, replacing teeth or structures directly supporting teeth.
- 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.

(5) Orthotic Devices. The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered Services. The casting is a Covered Service when an orthotic appliance is billed with it, but not if billed separately.

(a) Covered Services include the following.

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

(b) Orthotic appliances may be replaced one time per Plan Year unless specifically approved in writing by us. Additional replacements will be allowed for Covered Persons under age 18 due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

(c) Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

(d) Non-Covered Services include the following.

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

(6) Prosthetic limbs & Orthotic custom fabricated brace or support. Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be a Covered Service if they are determined by your physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities, and are not solely for comfort or convenience.

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

(b) Prosthetic limbs and orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

(7) Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below, as approved by us.

(a) The repair, adjustment or replacement of the purchased equipment, supply or appliance is a Covered Service if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.

- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

(b) Replacement of purchased equipment, supplies or appliance may be a Covered Service if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

(c) Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

M. Outpatient Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital or other facility as determined by us. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation.

(2) Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to Article 3 Section B for Behavioral Health Services covered by this Contract.

(3) Professional charges only include services billed by a physician or other professional.

(4) When Diagnostic Services or other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Service, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

(5) For Emergency Care refer to the section titled Emergency Services.

N. Autism Spectrum Disorder Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Autism Spectrum Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(2) Coverage is provided for the treatment of Autism Spectrum Disorders, including behavioral therapies such as Applied Behavior Analysis (ABA). Benefits are limited to Health Care Services prescribed by your physician in accordance with a treatment plan. Coverage for Health Care Services will be provided as prescribed by your treating physician in accordance with the treatment plan.

(3) Any exclusion or limitation in this Contract in conflict with the coverage described in this section will not apply.

(4) Coverage for Autism Spectrum Disorders will not be subject to limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Contract.

O. Physician Home Visits and Office Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service a Health Care Service must be Medically Necessary.

(1) Covered Services include care provided by a physician, including employees of the physician such as an advanced practice nurse or physician assistant, in his/her office or your home. Refer to the sections titled Preventive Care, Maternity Care, Home Care Services, and Behavioral Health Care Services for services covered by this Contract. For Emergency Care refer to the Emergency Services section.

(2) Office visits for medical care and consultations to examine, diagnose, and treat a Sickness or injury performed in the physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a physician's office, no Copayment is required however Coinsurance will apply.

(3) Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

(4) Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

(5) Surgery and surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

(6) Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a physician or other professional Provider.

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

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

(2) Preventive Care Services in this section shall meet requirements as determined by federal and state law.

(a) Health Care Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF. Covered Services include the screenings for following.

- Breast cancer.
- Cervical cancer.
- Colorectal cancer.
- High Blood Pressure.
- Type 2 Diabetes Mellitus.
- Cholesterol.
- Child and Adult Obesity.
- For Covered Persons age 15 – 65 and other ages at increased risk, Human Immunodeficiency Virus (HIV)
- Depression for adults
- Screening for alcohol misuse

(b) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(c) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Well Baby visits and care.
- Newborn screening for hearing
- Lead screening for children at risk for exposure
- Depression screening for adolescents

(d) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Women's contraceptives, sterilization procedures, and counseling. This includes generic drugs only, unless there is no generic equivalent, obtained from a Participating Pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms and intrauterine devices (IUDs) are also covered. When generic equivalents are available, prescription brand name contraceptives will not be covered under the Preventive Care benefit. Instead, prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the Prescription Drug Benefits section.
- Breastfeeding support, supplies, and counseling.
- Gestational diabetes screening.

(3) Covered Services also include the following services required by state law:

(a) Breast Cancer Screening. The following are Covered Services.

(a) If the female Covered Person is at least 35 years of age, one (1) baseline breast cancer screening mammography performed before she becomes 40 years of age.

(b) If the female Covered Person is less than 40 years of age and is high risk, one (1) breast cancer screening mammography performed every year. A woman is considered "high risk" if she meets at least one (1) of the following.

(A) Has a personal history of breast cancer.

(B) Has a personal history of breast disease proven benign by biopsy.

(C) Has a mother, sister, or daughter who has had breast cancer.

(D) Is at least 30 years of age and has not given birth.

(c) Any additional mammography views that are required for proper evaluation.

(d) Ultrasound services, if determined Medically Necessary by the physician treating the Covered Person.

(b) Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Service for a Covered Person under the age of fifty (50) if the Covered Person is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsymptomatic Covered Person, in accordance with the current American Cancer Society guidelines.

(c) Diagnostic Prostate Cancer Screening. If male Covered Person is at least 50 years of age, one (1) prostate specific antigen test annually is a Covered Service. If a male Covered Person is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test annually is a Covered Service.

Q. Surgical Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes the following.

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

(2) The surgical fee includes normal post-operative care.

(3) We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact us for more information.

(4) Covered Surgical Services include the following.

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

R. Reconstructive Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

(2) Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract.

(3) Covered Services are limited to the following.

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

(4) For a Covered Person who has undergone a mastectomy Covered Services include the following.

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

S. Sterilization.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

Sterilization is a Covered Service.

T. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

(2) Covered Services include removable appliances for repositioning and related surgery, medical care, and diagnostic services.

(3) Non-Covered Services include the following:

- Fixed or removable appliances that involve movement or repositioning of the teeth.
- Repair of teeth (fillings).
- Prosthetics (crowns, bridges, dentures).

U. Therapy Services.

Benefits are provided for therapy services that can be Rehabilitative or Habilitative. For purposes of this section and the Schedule of Benefits, the following definitions apply:

- Rehabilitation refers to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech therapy and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Physical therapy.

(a) Physical therapy includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve

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

(b) Non-Covered Services include the following.

- 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.

(3) Speech Therapy. Speech therapy for the correction of a speech impairment.

(4) Occupational Therapy. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

(a) Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

(b) Non-Covered Services include the following.

- Supplies (looms, ceramic tiles, leather, utensils).
- Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again.
- General exercises to promote overall fitness and flexibility.
- Therapy to improve motivation.
- Suction therapy for newborns (feeding machines).
- Soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial.
- Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

(5) Manipulation Therapy. Manipulation Therapy includes osteopathic/chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

(a) Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any limitation for Manipulation Therapy services as specified in the Schedule of Benefits.

(b) Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

(6) Other Therapy Services

(a) Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

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

(c) Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage this Contract will not require you to receive dialysis treatment at a Participating Provider that is a dialysis facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Participating Dialysis Facility is more than 30 miles from your home, you may, upon our prior written consent, receive treatment at a Non-Participating Provider that is a dialysis facility nearest to your home as Covered Service.

(d) Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

(e) Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to:

- Introduction of dry or moist gases into the lungs.
- Nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication.
- Continuous positive airway pressure ventilation (CPAP).
- Continuous negative pressure ventilation (CNP).
- Chest percussion.
- Therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers.
- Broncho-pulmonary drainage.
- Breathing exercises.

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

V. Physical Medicine and Rehabilitation Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

(2) The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting. Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

(3) Non-Covered Services include the following.

- Admission to a Hospital mainly for physical therapy.
- Long term rehabilitation in an Inpatient setting.

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

W. Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Cost Sharing.

(2) "Covered Transplant Procedure" includes any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

(3) "Transplant Benefit Period" starts one day prior to a covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.

(4) Transplant services require Precertification.

(5) Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are a Covered Service as routine Diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

(6) Transportation and Lodging. This Contract will provide assistance with reasonable and necessary travel expenses as determined by us when you obtain Precertification and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when claims are filed.

(7) Non-Covered Services for transportation and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

X. Prescription Drug Benefits

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Pharmacy Benefits Manager (PBM).

(a) The Prescription Drug benefits are managed by our Pharmacy Benefits Manager or PBM. The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy, a Specialty Pharmacy, and provides clinical management services. The management and other services the PBM provides include, making recommendations to, and updating, the "covered Prescription Drug list" (the "covered Prescription Drug list" is referred to as the "Formulary"), managing a network of retail pharmacies, operating a mail service pharmacy, and operating a Specialty Pharmacy network.

(b) The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of Prescription Drug benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions or drug/pregnancy concerns. You may request a copy of the Formulary by calling the Customer Service telephone number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage.

(c) For certain Prescription Drugs, the prescribing Provider may be asked to provide additional information before the PBM and/or we can determine Medical Necessity. We may, in our sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer.

(d) Precertification may be required for certain Prescription Drugs (or the prescribed quantity of a particular Prescription Drug). At the time you fill a prescription, the Participating Pharmacy is informed of the Precertification requirement through the Participating Pharmacy's computer system. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee which is reviewed and adopted by us.

(e) For a list of the current Prescription Drugs requiring Precertification, please contact the Customer Service telephone number on the back of your Identification Card or go to our website at [insert url to formulary]. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage. Your Provider or Participating Pharmacy may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under this Contract.

(2) Therapeutic Substitution of Prescription Drugs. This is a voluntary program designed to inform Covered Persons and Providers about possible substitutes to certain Prescription Drugs. We, or the PBM, may contact you and your prescribing Provider to make you aware of substitution options. Therapeutic substitutes may also be initiated at the time the Prescription Drug is dispensed.

(a) Only you and your Provider can determine whether the therapeutic substitute is appropriate for you.

(b) For questions or issues involving therapeutic substitutes, call the Customer Service telephone number on the back of your Identification Card.

(c) The therapeutic substitutes list is subject to periodic review and amendment.

(3) Step Therapy. Step therapy protocol means that a Covered Person may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Covered Persons access high quality yet cost effective Prescription Drugs. If a Provider decides that the monitored medication is needed the Precertification process is applied.

(4) Participating Specialty Pharmacy. The PBM's Specialty Pharmacy is available to Covered Persons who use Specialty Drugs.

(a) "Specialty Drugs" are Prescription Legend Drugs that are one of the following:

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

(b) Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, subject to a day supply limit for retail and mail service, and the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

(c) Questions regarding Specialty Drugs can be directed to the Customer Service telephone number on the back of your Identification Card.

(d) You may obtain a list of the Participating Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your Identification Card, or review the lists on our website at [insert address].

(5) Covered Services include the following.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Self-administered contraceptives, including oral contraceptives, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the Preventive Care section, please see that section for more details.
- Selected drugs to eliminate or reduce dependence on, or addiction to tobacco and tobacco products.
- Injectables.
- Selected preventive medications are covered with no Copayment or Coinsurance if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations. These medications include the following: vitamin D supplementation, folic acid supplementation, aspirin and oral fluoride supplementation.

(6) In addition to the Exclusions set forth in Article 4, Non-Covered Services include the following.

- Prescription Drugs dispensed by any mail service program other than the PBM's mail service pharmacy, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.

- Off label use, except as otherwise prohibited by law or as approved by us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription.
- Drugs not approved by the FDA except as otherwise prohibited by law.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a physician. This does not apply to drugs used in conjunction with a Diagnostic Service, with chemotherapy performed in the office or drugs eligible for coverage under the Medical Supplies benefit.
- Any drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by this Contract, or which exceed any age limits established by us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility drugs.
- Human growth hormone for children born small for gestational age.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact us for additional information on these Prescription Legend Drugs.
- Refills of lost or stolen medications.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, unless otherwise required by law or approved by us. "Clinically equivalent" means drugs that, for the majority of persons, can be expected to produce similar therapeutic outcomes for a disease or condition.

(7) If you have questions regarding whether a particular Prescription Drug is covered and which Tier a Prescription Drugs fall into, please call the Customer Service telephone number on the back of your Identification Card, or visit our website at [website address].

(8) Each Prescription Drug may be subject to a Deductible, Coinsurance or Copayment. If the prescription includes more than one covered Prescription Drug, a separate Coinsurance or Copayment will apply to each covered Prescription Drug. Your Copayment will be the lesser of your scheduled Copayment or the Allowable Amount.

(9) The number of days' supply of a Prescription Drug which you may receive is limited. The days' supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days' supply allowed for under this Contract, you should ask your Pharmacist

to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

(10) Your Copayment or Coinsurance amount may vary based on whether the Prescription Drug has been classified by us as a first, second, third, fourth or fifth "Tier" Prescription Drug. The determination of Tiers is made by us based upon clinical information, and where appropriate the cost of the Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

(a) Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This Tier will contain low cost and preferred generic medications as well as selected preventive medications that are covered with no Coinsurance or Copayment if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations.

(b) Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This Tier will contain non-preferred generic medications.

(c) Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This Tier will contain preferred brand name medications.

(d) Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This Tier will contain non-preferred brand name medications.

(e) Tier 5 Prescription Drugs will have a higher/comparative Coinsurance or Copayment than those in Tier 4. This Tier will contain medications that are considered Specialty Drugs.

We have established a Pharmacy and Therapeutics Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Precertification criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives. The Pharmacy and Therapeutics Committee also determines, where appropriate, the cost of a Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one drug over another in our patient program, and, where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by

mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

(11) From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, generic, mail service, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Prescription Drugs or preferred products for a limited period of time.

(12) The amount of Benefits paid is based upon whether you receive the Covered Services from a Participating Pharmacy, including a Participating Specialty Pharmacy, a Non-Participating Pharmacy, or the PBM's mail service program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug.

(13) How you obtain your Benefits depends upon whether you go to a Participating or a Non-Participating Pharmacy.

(a) Participating Pharmacy – Present your written prescription from your physician and your Identification Card to the pharmacist at a Participating Pharmacy. The Participating Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment or Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge and you believe the Prescription Drug should be covered, ask your pharmacist for an itemized receipt and submit it to us for reimbursement consideration.

(b) Specialty Drugs - You or your Provider can order your Specialty Drugs directly from a Participating Specialty Pharmacy, simply call the Customer Service telephone number on the back of your Identification Card. Your Specialty Drug may need Precertification prior to dispensing. Upon approval, your Specialty Drug will be delivered to your physician's office/your specified delivery location based on the physician's order. A clinician will be available to answer any questions you may have in regard to the Specialty Drug and the instructions.

(c) Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy, including a Non-Participating Specialty Pharmacy. You must submit a claim for reimbursement consideration as set forth in Article 8 Section C.

(d) The Mail Service Program – Complete the order and patient profile form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have your physician fax the prescription to the mail service pharmacy. Your physician may also phone in the prescription to the mail service pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the mail service pharmacy when you request a prescription.

(14) Drug Exception Program. This is a program designed to allow Covered Persons to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. Please call the Customer Service number on the back of your Identification Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or are currently undergoing a course of treatment using a Prescription Drug that is not on the Formulary, you may request an expedited review of your request for a drug exception. In such circumstances, we will provide you or your Designated Representative with our decision within twenty-four (24) hours after we receive your request.

Y. Pediatric Vision Services. The following Health Care Services are Covered Services only for Covered Person through the age of nineteen (19). The Contract only provides Benefits for vision care that is listed in this section.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A complete pediatric eye exam. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together. The exam may include the following.

- Case History.
- Cover test.
- Ocular Motility.
- Neurological Integrity.
- External Exam.
- Internal Exam.
- Retinoscopy.
- Phorometry testing.
- Point refraction.
- Tonometry.
- Opthalmoscopic exam.
- Confrontation Visual Fields.
- Biomicroscopy.
- Color Vision Testing.
- Diagnosis/Prognosis.
- Recommendations.

(2) Eyeglass Lenses. Lens options include a choice of plastic or polycarbonate. Lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include up to 55 mm in single vision, bifocal, trifocal or lenticular.

(3) Frames. This Contract offers a selection of frames that are covered.

(4) Contact Lenses. Coverage includes the following.

(a) Contact Lens professional fitting fees.

(b) Elective Contact Lenses (elective contact lenses are contacts that are chosen for comfort or appearance).

(c) Non-Elective Contact Lenses are only provided for the following medical conditions.

- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when the patient's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

(d) Medically Necessary contact lenses are available in lieu of ophthalmic lenses and may be subject to Copayments, Coinsurance and limitations. The Provider determines a patient's qualifying criteria at examination and evaluation, and will obtain any necessary Precertification from us for these services.

(5) Low Vision Benefits

(a) Comprehensive Low Vision Exam.

(b) Optical/Non-optical aids.

(c) Supplemental testing.

(6) Non-Covered Services include services incurred for, or in connection with, any of the items below.

- Non-elective contact lenses for any Covered Person who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- For safety glasses and accompanying frames.
- For Inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Covered Person has reached the normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Contract.

- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Vision services for Covered Persons over the age of nineteen (19) unless specifically stated in this Contract.

ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS

A. Non-Covered Services:

This Article 5 sets forth services that are excluded from coverage under this Contract and therefore are Non-Covered Services. Non-Covered Services are not covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

B. **Exclusions**. The following are Non-Covered Services:

(1) Services that we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.

(2) Services received from an individual or entity that is not a Provider.

(3) Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.

(4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

(5) Services provided as benefits by any governmental unit, unless otherwise required by law or regulation.

(6) Services for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

(7) Services for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

(8) Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

(9) Court ordered testing or care unless Medically Necessary.

(10) Services for which you have no legal obligation to pay in the absence of this or like coverage.

(11) Charges for consulting with Covered Persons by telephone, facsimile, electronic mail systems or other consultation or medical management service not involving

direct (face-to-face) care with the Covered Person except as otherwise described in this Contract.

(12) Surcharges for furnishing and/or receiving medical records and reports.

(13) Charges for doing research with Providers not directly responsible for your care.

(14) Charges that are not documented in Provider records.

(15) Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.

(16) Administrative or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

(18) Services prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

(19) Completion of claim forms or charges for medical records or reports unless otherwise required by law.

(20) Missed or canceled appointments.

(21) Mileage, lodging and meals costs, and other travel related expenses, except as authorized by us or specifically stated as a Covered Service in this Contract.

(22) Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.

(23) Services incurred prior to the Effective Date.

(24) Services incurred after the termination date of this coverage except as specified elsewhere in this Contract.

(25) For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Complications directly related to Cosmetic Services treatment or surgery, as determined by us, are not covered. This exclusion applies even if the original Cosmetic Services treatment or surgery was performed while the Covered Person was covered by another carrier/self-funded

plan prior to coverage under this Contract. "Directly related" means that the treatment or surgery occurred as a direct result of the Cosmetic Services treatment or surgery and would not have taken place in the absence of the Cosmetic Services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

(26) Maintenance Therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance Therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

(27) Custodial Care, convalescent care or rest cures.

(28) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

(29) Services provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

(30) Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

(31) Services or care provided or billed by a school, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(32) Wilderness camps.

(33) For routine foot care (including the cutting or removal of corns and calluses), Nail trimming, cutting or debriding, Hygienic and preventive maintenance foot care, including but not limited to 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.

(34) Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

(35) Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to the following.

- Extraction, restoration and replacement of teeth.

- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

(36) 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.

(37) Dental implants.

(38) Dental braces.

(39) Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following.

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer or cleft palate.

(40) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

(41) Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

(42) Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by us, are not covered. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(43) Marital counseling.

(44) Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

(45) Vision orthotic training.

(46) Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.

(47) Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

(48) Services to reverse voluntarily induced sterility.

(49) Diagnostic testing or treatment related to infertility.

(50) Personal hygiene, environmental control, or convenience items including but not limited to the following.

- Air conditioners, humidifiers, air purifiers.
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals.
- Charges for non-medical self-care except as otherwise stated.
- Purchase or rental of supplies for common household use, such as water purifiers.
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds.
- Infant helmets to treat positional plagiocephaly.
- Safety helmets for Covered Persons with neuromuscular diseases.
- Sports helmets.

(51) Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

(52) Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by us, or as otherwise described in this Contract.

(53) Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.

(54) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

(55) For self-help training and other forms of non-medical self-care, except as otherwise provided in this Contract.

(56) Examinations relating to research screenings.

(57) Stand-by charges of a Provider.

(58) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

(59) Services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

(60) Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Contract.

(61) Manipulation Therapy services rendered in the home as part of Home Care Services.

(62) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. This Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

(63) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

(64) Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

(65) Any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(66) Surgical treatment of gynecomastia.

(67) Treatment of hyperhidrosis (excessive sweating).

(68) Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by us through Precertification.

(69) Complications directly related to a service or treatment that is a Non-Covered Service under this Contract because it was determined by us to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

(70) Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

(71) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

(72) Treatment of telangiectatic dermal veins (spider veins) by any method.

(73) Reconstructive services except as specifically stated in this Contract or as required by law.

(74) Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

(75) For non-preventive medical nutritional therapy.

(76) Abortions that are not Therapeutic Abortions.

C. Experimental/Investigative Health Care Services Exclusion. We do not provide coverage for any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be Experimental/ Investigative.

(1) 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.

(a) 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 granted.

(b) Has been determined by the FDA to be contraindicated for the specific use.

(c) Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

(e) 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.

(2) Any Health Care Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by us. In determining whether a Health Care Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

(a) The scientific evidence is conclusory concerning the effect of the Health Care Service on health outcomes.

(b) The evidence demonstrates the Health Care Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects.

(c) The evidence demonstrates the Health Care Service has been shown to be as beneficial for the total population for whom the Health Care Service might be proposed as any established alternatives.

(d) The evidence demonstrates the Health Care Service has been shown to improve the net health outcomes of the total population for whom the Health Care Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(3) Off-Label Drug Treatment. Coverage for a drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

(a) The drug is recognized for treatment of the indication in at least one standard reference compendium.

(b) The drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the drug's use to be contraindicated or the drug has not been approved by the FDA for any indication.

(4) The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

(a) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.

(b) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.

(c) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Documents of an IRB or other similar body performing substantially the same function.

(e) Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(f) Medical records.

(g) The opinions of consulting Providers and other experts in the field.

ARTICLE 6. OBTAINING COVERED SERVICES

A. Participating Providers.

(1) Unless otherwise specifically provided in this Contract, in order to receive Benefits under this Contract, a Covered Person must receive Covered Services from a Participating Provider.

(2) The Covered Person is responsible for verifying that a Provider is a Participating Provider. A list of Participating Providers is available online at [insert website] or by calling us at [toll free number].

B. Non-Participating Providers. Health Care Services received from Non-Participating Providers are Non-Covered Services except for the following circumstances.

(1) Emergency Health Care Services.

(a) If we determine that the Health Care Services were not an Emergency, the Health Care Services are Non-Covered Services and you will be responsible for costs associated with the Health Care Services.

(b) Subsequent follow up care by a Non-Participating Provider after the condition is no longer an Emergency is a Non-Covered Service unless specifically authorized by us.

(c) If a Covered Person is hospitalized in a Non-Participating Hospital due to an Emergency, you or the Provider must notify us within 48 hours of the admission. A continued stay after the condition is stabilized and is no longer an Emergency requires our written authorization. We may elect to transfer the Covered Person to a Participating Hospital once it is medically appropriate to do so.

(2) Non-emergency Medically Necessary Health Care Services that cannot be provided by a Participating Provider and for which the Covered Person has obtained a Referral from his/her Primary Care Physician.

(3) Maternity services for a Covered Person who was in her second or third trimester of pregnancy as of her Effective Date as provided in Article 3 Section K.

(4) When our agreement with a Participating Provider terminates, upon your written request, the Covered Person may continue to receive Covered Services from the Provider for the following time periods.

(a) Up to sixty (60) days.

(b) In the case of Covered Person who is pregnant and in the third trimester of pregnancy, you may continue to receive Covered Services through the term of the pregnancy.

(c) For a Covered Person who is hospitalized until the Covered Person is discharged from Inpatient status.

C. Primary Care Physician.

(1) You must designate a Primary Care Physician for each Covered Person. If you do not select a Primary Care Physician we will assign one.

(2) The Covered Person's Primary Care Physician will be responsible for coordinating Covered Services and making referrals to other Participating Providers. A Covered Person does not need a referral from his/her Primary Care Physician for obstetrical or gynecological treatment from a Participating Provider. A Covered Person may seek care directly from an obstetrician or gynecologist that is a Participating Provider. For all other Providers, the Covered Person must obtain a referral from his/her Primary Care Physician to obtain benefits for Covered Services under this Contract.

(3) You may change the selection of a Primary care Physician no more frequently than once each month. A Covered Person may change his/her Primary Care Physician by submitting a written request, online at [insert website address], or by contacting us at the number shown on your Identification Card. A change in Primary Care Physician selection will be effective no later than thirty (30) days from the date we receive a request.

ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES.

This Article 7 sets forth the procedures for requesting approvals for Covered Services from us as well as general Grievance procedures. In processing claims, we review requests for Precertification, Predetermination, and Post Service Clinical Claims Review to determine whether provided or proposed to be provided Health Care Services are Covered Services. Health Care Services must be Medically Necessary for Health Care Services to be considered Covered Services.

A. Covered Service Review Requests

(1) Types of Covered Service Review Requests.

(a) Precertification – 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.

(b) Predetermination – An optional, voluntary prior or concurrent request for a benefit coverage determination for a Health Care Service. We will review this Contract to determine if there is an Exclusion for the service or treatment requested. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service or treatment meets our definition of Medical Necessity, or if it is Experimental/Investigative as that term is defined in this Contract.

(c) Post Service Clinical Claims Review – A retrospective review (Post-Service) for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Precertification and did not undergo a Predetermination review. Post Service Clinical Claims Reviews are done for Health Care Services for which we have a related clinical coverage guideline and are typically initiated by us.

(2) Most Participating Providers know which Health Care Services require Precertification and will get Precertification or ask for Predetermination from us as needed. The Covered Person's Primary Care Physician and all other Participating Providers have received information from us on the procedures for requesting approvals for Covered Services and are responsible for meeting the requirements under such procedures. Generally, the Participating Provider ordering the service, treatment or admission will contact us to ask for Precertification or Predetermination reviews ("Requesting Provider"). We will work directly with the Requesting Provider regarding such review requests; however, the Covered Person's Designated Representative may act on the Covered Person's behalf throughout the review process.

(3) We will utilize our clinical coverage guidelines, including internally developed guidelines, procedures, and preventative care clinical coverage guidelines, to help us determine whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions Identified

as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

(4) The Covered Person is entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact us at [toll free number].

B. Review Request Categories.

(1) Urgent Care – A request for Precertification or Predetermination that in the view of the attending Provider, or any physician with knowledge of the Covered Person's medical condition, could seriously jeopardize the Covered Person's life or health or the Covered Person's ability to regain maximum function, or would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Urgent Care Claim.

(2) Pre-Service – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

(3) Concurrent Care – A request for Precertification or Predetermination that is conducted during an ongoing course of treatment or admission. If we have approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by us of such course of treatment before the end of such period of time or number of treatments shall constitute a benefit determination adverse to the Covered Person. We will notify the Covered Person sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination before the benefit is reduced or terminated.

(4) Post-Service – A request for approval that is made after the service, treatment or admission has occurred. Post-Service review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

C. Benefit Decision and Notice Requirements.

(1) We will resolve benefit review requests according to the timeframes listed in the table below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws.

Request Categories	**Timeframe Requirement for Benefit Decisions and Notification**
Pre-Service Claim	15 calendar days from receipt of request
Pre-Service Urgent Care Claim	72 hours from receipt of request

Concurrent Care Claim	15 calendar days from receipt of request
Concurrent Urgent Care Claim	24 hours from receipt of request
Post-Service Claim	20 business days from receipt of request

D. Timeframe Extensions for Benefit Decisions and Notifications.

(1) Post-Service and Pre-Service Claims. If we are unable to complete our review due to circumstances beyond our control, we will notify the Covered Person, the Covered Person's Designated Representative, and the Requesting Provider in writing within:

(a) Fourteen (14) days after our receipt of a Pre-Service claim review request, and

(b) Nineteen (19) days after our receipt of a Post-Service claim review request.

The written notice will include the reason for the delay, a list of any applicable additional information that we need from the Covered Person in order to complete our review and a revised timeframe for the resolution. If the reason for the delay is because the Covered Person's review request lacked sufficient information to complete our review of the Covered Person's request, the Covered Person, the Covered Person's Designated Representative and Requesting Provider will have forty-five (45) days from receiving our notice of delay to provide the necessary information. We will notify the Covered Person, the Covered Person's Designated Representative and the Requesting Provider of our decision within not more than ten (10) days after notifying the Covered Person, the Covered Person's Designated Representative and Requesting Provider of the reason for our delay or of our receipt of the necessary information or of the end of the period afforded to the Covered Person to supply the necessary information, as applicable. If we do not get the specific information we need or if the information is not complete by the timeframe provided to the Covered Person, we will make a decision based upon the information we have.

(2) Urgent Care Claims. If the Covered Person fails to provide us with sufficient information to review the Covered Person's Urgent Care Claim review request, we will notify the Covered Person as soon as possible, but not later than twenty-four (24) hours after our receipt of the claim, of the specific information necessary to complete our review. The Covered Person will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. We will notify the Covered Person, the Covered Person's Designated Representative and Requesting Provider of our decision as soon as possible, but in no case later than forty-eight (48) hours of the earlier of the following:

(a) our receipt of the necessary information, or

(b) the end of the period afforded to the Covered Person to supply the necessary information.

If we do not get the specific information we need or if the information is not complete by the timeframe provided to the Covered Person, we will make a decision based upon the information we have.

E. Denial of Experimental Treatment.

(1) If we deny coverage for a treatment, procedure, drug or device on the grounds that the treatment, procedure, drug or device is experimental, we will provide the Covered Person with a written explanation that includes the following information:

(a) The basis for the denial.

(b) The Covered Person's right to Appeal our decision.

(c) Our telephone number that the Covered Person may contact for assistance in initiating an Appeal of our decision.

(2) If the Covered Person's health situation is life threatening or is an emergency, the Covered Person is entitled to a review of our decision to deny coverage on the grounds that the treatment, procedure, drug or device is experimental that takes not more than seventy-two (72) hours.

F. What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(1) Availability, delivery, appropriateness, or quality of health care services.

(2) Handling or payment of claims for health care services.

(3) Matters pertaining to the contractual relationship between you and us.

G. Who May File.

(1) You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

(2) If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

H. How a Grievance May Be Filed.

(1) You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, including fax]

(2) A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

I. No Retaliation. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 7.

J. Grievance Procedure.

(1) Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

(2) Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

(3) Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

(4) Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

(5) Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

K. Appeals Procedure.

(1) Right to an Appeal.

(a) If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

(b) You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

(c) The Appeal may be expressed orally or in writing by contacting us at the address and phone number provided below.

[Address]

(d) We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

(2) Appeal Panel.

(a) We will appoint a panel of qualified individuals to resolve your Appeal (the "Appeal Panel"). The Appeal Panel will resolve your Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

(b) The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date and place during normal business hours for the Appeal Panel to meet to discuss your Appeal. You will be given seventy-two (72) hours advance notice of the date and time of the meeting.

(c) You or Your Designated Representative may:

(a) appear in person before the Appeal Panel; or

(b) communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

(d) You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

(e) To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

(f) The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

(g) If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:

(a) Has knowledge in the medical condition and Health Care Service;

(b) Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and

(c) Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with you or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.

(3) Appeal Decision and Notice of Decision.

(a) The Appeal Panel's decision regarding your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

(b) The Appeal Panel will resolve Appeals according to the timeframes listed in the table below.

Appeal Categories	**Timeframe Requirement for Appeal Decisions and Notification**
Appeal of a Pre-Service Claim Decision	30 calendar days from our receipt of the Appeal
Appeal of a Pre-Service Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Concurrent Care Claim Decision	15 calendar days from our receipt of the Appeal
Appeal of a Concurrent Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Post-Service Claim Decision	45 calendar days from our receipt of the Appeal

(c) We shall notify the Covered Person or the Covered Person's Designated Representative of our decision in writing regarding the Appeal within five (5) business days after we complete our investigation.

(4) Expedited Review of Internal Appeals.

(a) An Expedited Review of an internal Appeal may be initiated orally, in writing or by other reasonable means available to the Covered Person, the Covered Person's Designated Representative or the Covered Person's Provider.

(b) Expedited Review is available only if the Covered Person's attending Provider believes that, based upon the Covered Person's medical condition, our standard internal Appeal procedure could seriously jeopardize the Covered Person's life or health or the Covered Person's ability to regain maximum function, or could subject the Covered Person to severe pain that cannot be adequately managed.

(c) Appeals of Urgent Care Claim decisions are referred directly to our Expedited Review procedure for investigation and resolution.

(d) We will complete our Expedited Review of the Appeal as soon as possible given the medical exigencies but no later than within 72 hours after our receipt of the Covered Person request for Appeal.

(e) We will communicate our decision regarding the Appeal by telephone to the Covered Person, the Covered Person's Designated Representative, and the Covered Person's attending Provider. We will also provide written notice of our decision to the Covered Person, the Covered Person's Designated Representative and the Covered Person's attending Provider.

(f) An Expedited Review of Concurrent Urgent Care Claims and Pre-Service Urgent Care Claims may occur at the same time as an External Review (as described below).

L. External Review

(1) The Covered Person or the Covered Person's Designated Representative may seek External Review if our decision regarding the Appeal upheld a decision that was adverse to you regarding any of the following.

(a) A Medically Necessary service.

(b) A utilization review decision.

(c) A determination that a proposed service is Experimental/Investigational.

(d) A decision to rescind the Covered Person's Contract.

If the Covered Person's Appeal did not involve one of the above adverse decisions, the Covered Person is not entitled to an External Review.

(2) If the Covered Person has the right to an External Review under Medicare (42 U.S.C. 1395, et seq.) the Covered Person may not request an External Review of our Appeals decision under the procedures outlined in this Contract.

(3) If the Covered Person's situation qualifies, the Covered Person or the Covered Person's Designated Representative must file a written request for an External Review with us within 120 days after the Covered Person receives notice of our internal response to the Appeal.

(4) Independent Review Organization (IRO).

(a) If an External Review is requested, we will forward all information related to the Covered Person's External Review to an IRO selected from the list of IROs that are certified by the Indiana Department of Insurance.

(b) The IRO will make a determination to uphold or reverse our Appeal decision within seventy-two (72) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or

within fifteen (15) business days if the condition does not involve an Urgent Care Claim.

(c) The IRO will notify the Covered Person and the Covered Person's Designated Representative of its decision within twenty-four (24) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within seventy-two (72) hours if the review does not involve an Urgent Care Claim.

(d) If the IRO decision reverses our Appeals decision, we will notify the Covered Person, the Covered Person's Designated Representative or Provider in writing of the steps we will take to comply with the Iron's decision.

M. Important Contact Information and Notice to Covered Persons

(1) Questions regarding the Covered Person's coverage should be directed to: Indiana University Health Plans; [toll free number]

(2) If the Covered Person (a) needs the assistance of the governmental agency that regulates insurance; or (b) has a complaint the Covered Person has been unable to resolve with us the Covered Person may contact the Department of Insurance by mail, telephone or email:

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

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

Complaints can also be filed electronically at www.in.gov/idoi.

(3) The review procedures described in this Article 7 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

ARTICLE 8. PAYMENT FOR COVERED SERVICES

A. How to Obtain Benefits.

(1) Whenever the Covered Person receives Health Care Services, the Covered Person must provide the Provider with a copy of the Covered Person's Identification Card.

(2) When the Covered Person receives Covered Services from a Participating Provider you are not required to file a claim. Since no claim filing is required, you are not required to follow the procedures outlined in Section C of this Article 8.

B. Who Receives Payment Under This Contract.

(1) We pay Benefits for the Covered Person's Covered Services directly to a Participating Provider.

(2) If the Covered Person receives Covered Services from a Non-Participating Provider as provided in Article 6 Section B, we will pay Benefits to the Non-Participating Provider, unless you agreed to make payment to the Non-Participating Provider and are entitled to reimbursement for such payment.

C. Payment for Covered Services received from Non-Participating Providers.

(1) Time to File Claims. For Covered Services received from a Non-Participating Provider, written notice of a claim must be given to us, by you or the Non-Participating Provider, within thirty (30) days of the date the Covered Services began. Failure to furnish the claim within thirty (30) days will not invalidate or reduce any claim if submission within thirty (30) days was not reasonably possible, so long as the claim is submitted within a reasonable time.

(2) Claim Forms. We shall provide forms to you for filing Proof of Loss within fifteen (15) days of notice of any claim. If you do not receive the forms within fifteen (15) days, written notice of services rendered may be submitted to us without the claim form. Claim forms are available on our website at [website address].

(3) Proof of Loss. Proof of loss under this Contract must be furnished to us within ninety (90) days after the loss. Failure to furnish the claim within ninety (90) days will not invalidate or reduce any claim if submission within ninety (90) days after the loss was not reasonably possible, so long as the claim is submitted within one (1) year after the time required under this Contract unless you were legally incapacitated.

(4) Address. All correspondence regarding claims should be sent to us at:

Indiana University Health Plans
[Address]
[City/state/zip]
[Fax]

(5) Amount of Payment. Payment for Health Care Services received from a Non-Participating Provider will be the lesser of the following amounts.

(a) The usual, customary and reasonable charge for the Health Care Service;

(b) An amount agreed upon by us and the Non-Participating Provider.

D. Clean Claims.

(1) A clean claim is a claim submitted by a Provider for payment that has no defect. We shall pay or deny each clean claim as follows.

(a) If the claim is filed electronically, within thirty (30) days after the date we receive the claim.

(b) If the claim is filed on paper, within forty-five (45) days after the date we receive the claim.

(2) If we fail to pay or deny a clean claim in the time frames set forth above and subsequently pay the claim, we will pay the Provider that submitted the claim allowable interest in accordance with Indiana Code § 27-8-5.7-6.

ARTICLE 9. COORDINATION OF BENEFITS

This Article applies only if you also have other health benefits coverage with another Plan. The Definitions contained in this Article apply throughout this Article 9 but do not apply to the rest of the Contract.

A. **When you have other health benefits**. In the event that you are covered by two health insurance contracts, plans or policies ("Plans") providing similar benefits and you receive a Health Care Service that would be covered by both Plans, we will coordinate benefit payments with any payment made under the other Plan. One company will pay its full benefit as the Primary Plan. The other company will pay Secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments.

B. **Definitions**.

(1) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the Plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(2) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

(3) "Closed Panel Plan" means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in the case of emergency or referral by a panel Covered Person.

(4) "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(5) "Plan" means any of the following that provides benefits or services for medical treatment:

(a) Any group or blanket insurance contract, plan or contract, except that blanket school accident coverage or such coverage offered to

substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or contract.

(b) Any self-insured or noninsured Plan or any other Plan arranged through an employer, trustee, union, employer organization or employee benefit organization.

(c) Any coverage under governmental programs or any coverage required to be provided by any statute. However, Medicaid and any Plan whose benefits are, by law, excess to those of any private insurance plan or other nongovernmental plan shall not be considered health insurance policies.

(d) Group or nongroup coverage through Closed Panel Plans or group type contracts.

(e) Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional "fault" type contracts.

(6) "Primary" or "Primary Plan" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If the Plan is Primary to another Plan, the Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(7) "Secondary" or "Secondary Plan" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If the Plan is Secondary to another Plan, the Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

C. Rules To Determine Payment. When two or more Plans pay benefits, the rules for determining the order of payments are as follows:

(1) The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

(2) If the other Plan does not have a provision similar to this one, then it will be primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(3) A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. Order of Determination of Benefits Rules: The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent is Primary, for example as an employee, subscriber or retiree is

primary and the Plan that covers the person as a Dependent is Secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent; then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, subscriber or retiree is Secondary and the other Plan is Primary.

(2) Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods commencing after the Plan is given notice of the court decree.

(d) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(a) The Plan of the Custodial Parent.

(b) The Plan of the spouse of the Custodial Parent.

(c) The Plan of the non-Custodial Parent.

(d) The Plan of the spouse of the non-Custodial Parent.

(3) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is Primary. The same would hold true is a person is a Dependent of a person covered as a retiree or an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined Section (C)(1) of this Article 9.

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, subscriber or retiree (or as that person's Dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, subscriber or retiree longer is Primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid if it had been Primary.

E. Payment of the Benefit When This Plan is Secondary.

(1) When this Plan is Secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other Plan and this Plan do not exceed your expenses for an item of service. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by the Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

(a) Determine its obligation to pay or provide benefits under its Plan;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

(2) If there is a benefit reserve, the Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

(3) If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, Coordination of Benefits shall not apply between that Plan and other Closed Panel Plans.

F. Payments to others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid.

G. Our Right to Recover Overpayment. In some cases, we may have made payment even though you had coverage under another Plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the

payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other Plan. You agree to sign any document that we deem necessary to help us recover any overpayment.

ARTICLE 10. TERMINATION OF COVERAGE

A. [**Guaranteed Renewable.** As long as a Covered Person continues to be a Qualified Individual and this Contract continues to be a Qualified Health Plan, you may renew this Contract at your option without regard to the health status of you or any Covered Person.]

[Guaranteed Renewable. Coverage under this Contract is guaranteed renewable at the discretion of the Subscriber, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, as described in this Article 10. The Subscriber may renew this Contract at the Subscriber's option without regard to the health status of you or any Covered Person. You may renew this Contract by payment of the renewal premium by the end of the Grace Period of the premium due date, provided the following requirements are satisfied:

(1) Eligibility criteria outlined in Article 2 continues to be met.

(2) There are no fraudulent or intentional misrepresentations on the application or under the terms of this Contract.

(3) Coverage has not been terminated by us under the terms of this Contract.]

B. **Termination.** We may terminate this Contract or coverage of a Covered Person for the following reasons.

(1) The Covered Person is no longer eligible for coverage [through the Indiana Marketplace].

(2) A Covered Person is no longer eligible under [the rules of the Indiana Marketplace or] the terms of this Contract.

(3) You do not pay premium and the applicable Grace Period has been exhausted.

(4) We receive a request from you to terminate the Contract.

(5) You or a Covered Person commits an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact.

(6) A Covered Person changes coverage to another [Qualified Health Plan] [health plan] during the [Indiana Marketplace] Open Enrollment Period or a Special Enrollment Period.

(7) [The Contract is no longer a Qualified Health Plan or we are decertified by the Indiana Marketplace.]

(8) You no longer reside in our Service Area.

(9) We discontinue a particular product provided that we provide you with written notice at least ninety (90) days before the date the product will be discontinued, we offer you the option to purchase any other individual contract we currently offer, and we act uniformly without regard to any health status-related factor.

(10) We discontinue all contracts in the individual market in Indiana provided that we provide you and the Indiana Department of Insurance with written notice at least 180 days before the date of the discontinuance, we discontinue and do not renew all contracts in the individual market in the State of Indiana, and we act uniformly without regard to any health status-related factor.

(11) We may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with the laws of the State of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

C. Effective Date of Termination. [Termination of this Contract automatically terminates all coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if this Contract is in effect at the time such services are provided.]

(1) If you terminate this Contract or coverage for a Covered Person, the last day of coverage [will be on the last day of the billing period for which premium has been paid. A request for termination must be received by us in writing] [is:

(a) The termination date specified by you, if reasonable notice is provided;

(b) If you do not provide reasonable notice, fourteen (14) days after the termination is requested, or

(c) If you do not provide reasonable notice and request a termination date in less than fourteen (14) days, on a date determined by us if we are able to implement termination in fewer than fourteen (14) days.]

(2) [If newly eligible for Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.]

(3) [If all Covered Persons are no longer eligible for coverage through the Indiana Marketplace, the last day of coverage is the last day of the month following the date notice is sent to us by the Indiana Marketplace, unless you request an earlier termination effective date.] [If you move outside of the Service Area, the last day of coverage for you and all of your Dependents will be at the end of the billing period that contains the date you no longer resided in the Service Area.]

(4) [If a Covered Person is no longer eligible for coverage under the rules of the Indiana Marketplace or the terms of this Contact, the last day of coverage is the last day of the month following the date the Covered Person loses eligibility.] [If a Dependent no longer meets the definition of Dependent, the last day of coverage for the Dependent will be on the last day of the billing period in which we received notice of the Dependents loss of eligibility.]

(5) In the case of a termination for non-payment of premium and the applicable Grace Period has been exhausted, the last day of coverage [for all Covered

Persons] will [be either the last day of the first month of the 3-month Grace Period or] the last day for which premium was paid.

(6) [In the case of a termination due to a change to another Qualified Health Plan, the last day of coverage is the day before the effective date of coverage in his or her new Qualified Health Plan.]

D. Notice of Termination.

(1) We shall provide you with written notice of our intent to terminate or not renew this Contract at least sixty (60) days prior to the effective date of the termination. This notice will identify the date upon which your coverage will terminate.

(2) Our notice to the Subscriber shall be deemed as notice to all Covered Persons and is sufficient if mailed to the Subscriber's address as it appears in our records.

(3) Termination of this Contract shall not prejudice any claim for Covered Services rendered before the effective date of the termination.

E. Continuation of Coverage.

(1) If we terminate this Contract, except for a termination due to our receivership, and a Covered Person is hospitalized for a medical or surgical condition on the effective date of the termination, coverage will continue for Inpatient Covered Services. Benefits shall end on the earliest of the following dates.

(a) The date the Covered Person is discharged from the Hospital.

(b) The date the Covered Person is covered under other health coverage if that coverage covers the Inpatient Hospital services.

(c) Sixty (60) days after the date this Contract ends.

(d) The last day the required premium has been paid if the Grace Period expires and the Subscriber has not made the required payment.

(e) The date the you terminate coverage.

(2) If this Contract terminates due to our receivership, coverage will continue for the following time period:

(a) The duration of the contract period for which premiums have been paid.

(b) If a Covered Person is hospitalized on the date of our receivership for the longer of the following time periods.

(A) The period ending when the Covered Person is discharged from the Inpatient hospitalization.

(B) The duration of the contract period for which premiums have been paid.

F. **Rescission.** If within two (2) years after the Effective Date of this Contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that the Subscriber or a Covered Person did not disclose on the application, we may rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding your newly born children within 31 days of birth), we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that the Subscriber or a Covered Person did not disclose on the application, we may rescind coverage for the additional Dependent as of his or her original Effective Date. Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by the Subscriber or a Covered Person may result in termination or rescission of coverage. The Subscriber is responsible to pay us for the cost of previously received services based on the Allowed Amount for such services, less any Copayments/Coinsurance paid or Premium paid for such services.

This Contract may also be terminated if the Subscriber or a Covered Person knowingly participates in or permit fraud of deception by any Provider, vendor or any other person associated with this Contract. Termination for any act, practice or omission that constituted fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give the Subscriber at least thirty (30) days written notice prior to the rescission of this Contract.

G. **Reinstatement.** If this Contract was terminated for non-payment of premium, you may request reinstatement of the Contract from [the Indiana Marketplace] [us] within 30 days of the effective date of the termination. You must remit all premium that was due for the coverage upon reinstatement. Upon [notice from the Indiana Marketplace and] receipt of the outstanding premium, we will reinstate coverage as of the effective date of the termination.

H. [**Certification of Prior Creditable Coverage If Required by Law.** If this coverage is terminated, all Covered Persons will receive certification from us showing that they were covered under this Contract. A Covered Person may need this certification document in order to purchase other health coverage. Certifications may be requested within twenty-four (24) months of losing coverage.

A Covered Person may also request certification be provided to he or she at any other time, even if he or she has not lost your coverage under this Contract. If a Covered Person has any other questions regarding certification of creditable coverage, contact the Customer Service telephone number on the back of your Identification Card.]

ARTICLE 11. GENERAL PROVISIONS

A. **Entire Contract**. This Contract, the Schedule of Benefits, and any application, rider or amendment(s) make up the entire agreement between you and us as of the Effective Date and supersede all other agreements. All statements made by you shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce coverage under this Contract or be used in defense of a legal action unless it is contained in the application.

B. **No Assignment**. The benefits provided under this Contract are for the personal benefit of all Covered Persons. You may not assign any of these rights to coverage. Any attempt by you to assign this Contract to any third party is void. Provided, however, that subject to our right to disapprove, you may assign your right to reimbursement for Covered Services to the Provider who provided such Covered Services.

C. **Notice**. Any notice that we give to you under this Contract will be mailed to your address as it appears on our records. Our notice to the Subscriber is deemed notice to all. Notice is deemed delivered three (3) calendar days after its deposit in the United State Mail with first class postage prepaid unless otherwise stated in this Contract. If you have to give us any notice, it should be mailed to:

Indiana University Health Plans, Inc.
950 North Meridian Street, Suite 200
Indianapolis, Indiana 46204

D. **Relationship Between Parties**. The relationships between us and Participating Providers are *solely* contractual relationships between a payor and independent contractors. Non-Participating Providers have no contractual relationship with us, nor are they our independent contractors. Providers are not our agents or employees. We and our employees are not employees or agents of Providers. The relationship between a Provider and any Covered Person is that of Provider and patient. The Provider is *solely* responsible for the services provided to any Covered Person.

E. **Disagreement with Recommended Treatment.** Each Covered Person enrolls in this Contract with the understanding that the Provider is responsible for determining the treatment appropriate for their care. The Covered Person may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate Health Care Services in a manner compatible with the Covered Person's wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice. If the Covered Person refuses to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, the Covered Person will be so advised. In such case, the Provider and we, as applicable, may determine that neither this Contract nor the Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of this Contract for the condition under treatment or any complications thereof.

F. **Your Medical Records**. As a condition precedent to the approval of claims hereunder, each Covered Person authorizes and directs any Provider that furnishes benefits hereunder to make available to us information relating to all Health Care Services, copies thereof and other records as needed by us for purposes of administering this Contract. In every case we will hold such information and records as confidential in accordance with state and federal confidentiality requirements.

G. **Second Opinion Policy**. A second opinion may be required at our discretion prior to the scheduling of certain Covered Services. We will advise you if a proposed Covered Service is subject to the second opinion policy. If so, you must consult with a second Participating Provider prior to the scheduling of the service. You must (a) contact us to obtain a list of Participating Providers who are authorized to render a second opinion, and (b) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider. You must obtain the second opinion within thirty-one (31) days of the first opinion or as soon thereafter as is reasonably possible. Second opinions we have arranged as described above are provided at no cost to you. A second opinion may also be obtained at the request of a Covered Person, subject to separate benefit restrictions and/or Copayments or Coinsurance described in this Contract.

H. **Who May Change This Contract**. This Contract may not be modified, amended or changed, except in writing, and signed by one of our officers. No employee, agent or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage or the conditions of eligibility, enrollment or participation unless in writing and signed by one of our officers. We are not bound by any verbal statements. We will provide the Subscriber with written notice of any material modification to this Contract not later than sixty (60) days prior to the date on which such material modification will become effective.

I. **Renewal Date**. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date for the term set forth in the Contract unless otherwise terminated by us as permitted by the Contract or by you upon thirty (30) days' prior written notice.

J. **Identification Cards**. Identification Cards are issued by us for identification only. Possession of any Identification Card confers no right to services or benefits under this Contract. To be entitled to such services or benefits the Covered Person's premiums must be paid in full at the time the Health Care Services are sought to be received. Coverage under this Contract may be terminated by us if the Covered Person allows another person to wrongfully use the Identification Cards.

K. **Right to Develop Guidelines and Administrative Rules**. We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Contract. An example of the use of the standards is to determine whether care was Medically Necessary. These standards will not be contrary to the descriptions in this Contract. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Contract.

L. **Non-Discrimination**. In compliance with state and federal law, we shall not discriminate on the basis of age; gender; color; race; disability; marital status; sexual preference; religious affiliation; or public assistance status. We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care. We shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew Coverage, (b) cancel coverage, (c) limit Benefits, or (d) charge a different premium. We shall not discriminate against victims of abuse in compliance with Indiana Code Sec. 27-8-24.3-1.

M. **Incontestability**. The validity of the Contract may not be contested after two (2) years, except for nonpayment of premiums or if the disputed statement is in a written instrument signed by the Subscriber. The ineligibility of Dependent under the Contract may be disputed at any time.

N. **Limitation of Action**. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Contract and within three (3) years from the date the Health Care Services were received.

O. **Examination of Covered Persons**. We may reasonably require that a Covered Person be examined if a question or dispute about the provision of or payment for Covered Services arises. The exam will be performed by a Participating Provider acceptable to us. We will pay for the exam.

P. **Right of Recovery.** If we pay for Health Care Services that, according to the terms of the Contract, should not have been paid, we reserve the right to recover such amounts from whom they have been paid (including the Covered Person or Provider) or any other appropriate party.

Q. **Contract is not a Medicare supplement policy**. Any Covered Services that are covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled. The benefits under this Contract for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be Primary. Where Medicare is Primary, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

R. **Contract is Not Worker's Compensation Insurance**. The coverage provided under this Contract does not replace, supplement or provide a substitute for benefits to which a Covered Person is entitled under worker's compensation, occupational disease, and similar laws. The Contract does not cover Health Care Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's

compensation, occupational disease and similar laws, even when the circumstances below are present.

(1) If the Covered Person's employer is not properly insured or self-insured under such laws.

(2) When a Covered Person refuses to use his or her employer's designated Provider.

(3) When a Covered Person has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

A Covered Person must contact his employer or its worker's compensation or occupational disease insurer for the provision or payment of such Health Care Services.

S. General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within our control we will pay benefits for Covered Services as provided in this Contract to the extent that facilities and personnel are then available, and we shall have no liability or obligation for delay or failure to provide Covered Services due to lack of available facilities or personnel.

T. Typographical or Administrative Error. Typographical or administrative errors shall not deprive a Covered Person of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

U. Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on the Effective Date shall apply. Any Contract provision which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

V. Governing Law. This Contract will be subject to the laws of the state of Indiana.

W. Severability. In the event that any provision in the Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

[Schedule of Benefits]

[Insert logo left/center/right]

INDIVIDUAL CONTRACT
[Issued through the Indiana Marketplace]
(herein called the "Contract")

[Product Name]

Issued by:

Indiana University Health Plans, Inc.
an Indiana domestic health maintenance organization
950 North Meridian Street
Indianapolis, Indiana 46204

[This coverage is issued through the Indiana Marketplace.] This Contract sets forth in detail your rights and obligations as a Subscriber. It is important that you **read this Contract carefully.** This Contract includes limitations and exclusions. You should familiarize yourself with its terms and conditions before receiving Health Care Services. Capitalized terms have the meaning set forth in the Definitions sections.

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, you may return it to us or the agent who sold it to you within 10 days after your receipt. Your premium will be refunded and this Contract with be void from its start. Any Health Care Services received during this 10-day period are solely your responsibility.

Benefits under this Contract may vary depending on other medical expense insurance you may have.

If you have questions related to your health insurance coverage, you may contact us at [toll free number] [or the Indiana Marketplace at www.healthcare.gov or [toll free number].]

[signature]
President

[**DISCLAIMER:** The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace.]

TABLE OF CONTENTS

PAGE

ARTICLE 1. DEFINITIONS 1
ARTICLE 2. ELIGIBILITY AND ENROLLMENT. 9
ARTICLE 3. YOUR FINANCIAL OBLIGATIONS 16
ARTICLE 4. COVERED SERVICES 19
ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS 54
ARTICLE 6. OBTAINING COVERED SERVICES 63
ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES 65
ARTICLE 8. PAYMENT FOR COVERED SERVICES 74
ARTICLE 9. COORDINATION OF BENEFITS 76
ARTICLE 10. TERMINATION OF COVERAGE 81
ARTICLE 11. GENERAL PROVISIONS 85

ARTICLE 1. DEFINITIONS

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Subscriber, who obtained this coverage through the Indiana Marketplace.]

[In this Contract, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc.. The term “you” refers to you, the Subscriber, in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.]

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.

Approved Clinical Trial – a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

(a) A trial that is approved or funded by one, or a combination, of the following.

(a) The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services.

(b) The United States Food and Drug Administration.

(c) The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(d) The United States Department of Veteran’s Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(e) The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).

(f) The Centers for Disease Control and Prevention.

(g) The Agency for Health Care Research and Quality.

(h) The Centers for Medicare and Medicaid Services (CMS).

(i) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks.

(j) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(k) A qualified non-governmental research entity in guidelines issued by the National Institutes of Health for center support grants.

(2) A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.

(3) A study or investigation done for drug trials which are exempt from the investigational new drug application.

For purposes of this definition, the term "life threatening condition" means any disease or condition from which death is likely unless the disease of condition is treated.

Behavioral Health – a physical or behavioral condition having an emotional or psychological origin or effect, including substance abuse. Behavioral Health Services include mental health services and substance abuse services.

Benefits – your right to payment for Covered Services under this Contract subject to the terms, conditions, limitations, and exclusions of this Contract.

Child or Children – a child of the Subscriber or Subscriber's spouse, including any of the following until the Child attains the age of 26.

- Natural child,
- Stepchild,
- Legally adopted child,
- Child placed for the purpose of adoption, or
- Child placed under legal guardianship or legal custody.

Child includes a child of any age who is incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 26 and the Subscriber principally supports the Child. Proof of the disability must be submitted to us within thirty-one (31) days of the child's 26th birthday. For two years we may require proof of the child's continuing disability and dependency at reasonable intervals. After two years, we may require proof of the child's disability and dependency no more than once per year.

Coinsurance – a percentage of the Allowed Amount that you must pay for certain Covered Services. Coinsurance amounts are set forth in the Schedule of Benefits.

Contract – this individual contract issued by Indiana University Health Plans, Inc. which provides Benefits for Covered Services received by the Subscriber and enrolled Dependents. The term Contract includes the Schedule of Benefits, any application, amendments and riders.

Copayment – a fixed amount you pay to a Provider for a Covered Service. The amount of a Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

Cosmetic Services – Health Care Services primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons.

Cost Sharing – the amount you are required to pay for Covered Services. Cost Sharing can be in the form of Copayments, Coinsurance or Deductibles.

Covered Person – you or any Dependent who meets all applicable eligibility requirements for coverage under this Contract, is enrolled as provided in this Contract, and for whom the required premium payment has been received by us.

Covered Services – Health Care Services performed, prescribed, directed or authorized by a Provider and for which this 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 this Contract is in force.
- Not experimental/investigative.
- Authorized in advance by us if Precertification is required under this Contract.
- Not excluded or limited by this Contract.

Deductible – the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The amount of the Deductible is set forth in the Schedule of Benefits.

Dependent – a person who is either the Subscriber's legal spouse or a Child.

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 [website] 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.

Durable Medical Equipment – Medical equipment that:

- can withstand repeated use and is not disposable,
- is used to serve a medical purpose,
- is generally not useful to a person in the absence of a Sickness or injury,
- is appropriate for use in the home, and
- is the most cost-effective type of medical apparatus appropriate for the condition.

Effective Date – the date when coverage under this Contract begins.

Emergency Medical Condition or Emergency – a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent 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 woman, the health of the woman or her unborn child) in serious jeopardy.

- Serious impairment to a person's bodily functions.
- Serious dysfunction of a bodily organ or part of a person.

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, 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, 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 woman 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 woman or the unborn child.

FDA – the United States Food and Drug Administration.

Grace Period – the time period for payment of premium set forth in Article 3 Section B.

Health Care Services – medical or health care services, whether or not covered under this 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.

Indiana Marketplace – the health benefit exchange established by the Affordable Care Act for the state of Indiana.

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

Medically Necessary – those Health Care Services that we determine to be all of the following.

(4) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for your illness, injury or disease.

(5) Required for the direct care and treatment or management of your illness, injury or disease.

(6) If not provided, your condition would be adversely affected.

(7) Provided in accordance with generally accepted standards of medical practice.

(8) Not primarily for the convenience of you, your family, the physician or another prescribing Provider.

(9) 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 your 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 your 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 used in this 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 – 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 this Contract.

Non-Participating Hospital – a Hospital that has not entered into a contractual agreement with us or is not otherwise engaged by us to provide Health Care Services to Covered Persons under this 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 Covered Persons under this Contract.

[**Open Enrollment Period** – the number of days each year during which individuals may enroll in a Qualified Health Plan through the Indiana Marketplace.]

[**Open Enrollment Period** – the number of days each year during which individuals may enroll for coverage under this Contract.]

Out of Pocket Maximum – the maximum amount you will pay for Covered Services in a Plan Year.

Outpatient – receipt of Health Care Services while not an Inpatient.

Participating Hospital – a Hospital 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 Covered Persons under this Contract.

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 Covered Persons under this Contract.

Plan Year – the calendar year during which this Contract is in effect. This Plan Year will be the 12 month calendar year except that if the Subscriber's Effective Date is after January 1st the Plan Year will begin on the Effective Date and end December 31st.

Precertification – 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.

Prescription Drug – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product, insulin, diabetic supplies, and syringes.

Prescription Legend Drug – A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

Primary Care Physician or 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 your medical care under this Contract.

Provider – a doctor, Hospital, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

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.

(1) The Health Care Service that is the subject of the Approved Clinical Trial.

(2) 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.

(3) 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.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) 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.

(6) A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.

(7) A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Qualified Health Plan – a health plan offered on the Indiana Marketplace that satisfies the requirements set forth under the Affordable Care Act (42 U.S.C. 18021(a)(1)).

[**Qualified Individual** – an individual who has been determined by the Indiana Marketplace to be eligible to enroll in a Qualified Health Plan.]

Schedule of Benefits – the part of this Contract that sets forth Cost Sharing, Out of Pocket Maximums, limitations and other information regarding your coverage under this Contract.

Service Area – the counties in which we are authorized to offer a qualified health plan. Our Service Area is [insert list of counties].

Sickness – a physical illness, disorder, or disease.

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.

[**Special Enrollment Periods** – enrollment periods administered by the Indiana Marketplace that occur outside of the Open Enrollment Period. Qualified Individuals and their dependents who are eligible for a Special Enrollment Period may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another during a Special Enrollment Period set for them by the Indiana Marketplace.]

[**Special Enrollment Periods** – enrollment periods administered by us that occur outside of the Open Enrollment Period.]

Spouse – the Subscriber's legal spouse.

Therapeutic Abortion – an abortion performed to save the life or health of the mother, or as a result of incest or rape

Urgent Care Claim – 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 your life, health or ability to reach and maintain maximum function.

- In the opinion of physicians familiar with your condition, would subject you to severe pain that cannot be adequately managed unless we approve the Claim.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT.

[This Contract is available through the Indiana Marketplace. The Benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Indiana Marketplace to be Qualified Individuals.]

A. **You as an Individual:** To be eligible for coverage as a Subscriber, an individual must meet the eligibility requirements listed below at the time of application and throughout the Plan Year.

(1) [Determined by the Indiana Marketplace to be a Qualified Individual for purposes of enrollment in a Qualified Health Plan.] [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective.]

(2) [Not incarcerated.] [Agree to pay the cost of the Premium that we require.]

(3) [A United States citizen or lawfully present non-citizen.] [Submit proof satisfactory to us to confirm Dependent eligibility.]

(4) A resident of the State of Indiana.

(5) Not entitled to or enrolled in Medicare or Medicaid.

(6) Not covered by any other group or individual health benefit plan.

B. **Your Dependents:** To be eligible as a Dependent, another person must either be your Spouse or your Child.

C. [**Other Rules About Eligibility.** No one will be denied enrollment or re-enrollment in this Contract because of health status, or the existence of a pre-existing physical or mental condition.]

D. **Open Enrollment**.

(1) [Notice of Annual Open Enrollment. Each calendar year the Indiana Marketplace will provide you with a written annual open enrollment notification no earlier than September 1, and no later than September 30.]

[Notice of Annual Open Enrollment. Each calendar year we will provide you with a prior written notice of the Open Enrollment Period.]

(2) [2015 Open Enrollment Period. For this Plan Year beginning on January 1, 2015, the Open Enrollment period begins on November 15, 2014 and extends through February 15, 2015.]

(3) [Effective Dates for Coverage Selected During 2015 Open Enrollment. For this Plan Year beginning on January 1, 2015, the following Effective Dates will apply:

(a) January 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace on or before December 15, 2014.

(b) February 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from December 16, 2014 through January 15, 2015.

(c) March 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from January 16, 2015 through February 15, 2015.]

(4) [Effective Dates for Coverage Selected During Annual Open Enrollment. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if we receive the application and initial premium payment between the 1st and 15th of the month. If we receive the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st)]

E. [**Special Enrollment Period.**

(1) Special Enrollment Triggering Events. The Indiana Marketplace must allow Qualified Individuals and their Dependents to enroll in a Qualified Health Plan or change from one Qualified Health Plan to another as a result of experiencing any of the following triggering events:

(a) Loss of Minimum Essential Coverage.

(b) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(c) Gaining status as a citizen, national, or lawfully present individual.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services ("HHS"), or its instrumentalities as evaluated and determined by the Indiana Marketplace. In such cases, the Indiana Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to a new service area of the Indiana Marketplace.

(h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(i) Demonstration to the Indiana Marketplace, in accordance with guidelines issued by HHS, that you or your Dependent meets other exceptional circumstances as the Indiana Marketplace may provide.

(j) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.)

(2) Indiana Marketplace Administration of Special Enrollments. For additional information on special enrollment triggering events and how to enroll in or change a Qualified Health Plan during a Special Enrollment Period, you should contact the Indiana Marketplace at [toll free number] or visit the Indiana Marketplace website at [www.healthcare.gov].

(3) Notice Requirement for Special Enrollments. Unless specifically stated otherwise in the applicable Indiana Marketplace rules, a Qualified Individual or Dependent has sixty (60) days from the date of a special enrollment triggering event to select a Qualified Health Plan.

(4) Special Enrollment Effective Dates. The Effective Date for coverage obtained under this Contract during a Special Enrollment Period depends on the type of triggering event that qualified the individual and/or dependent for the Special Enrollment Period as well as the date the Indiana Marketplace received the Qualified Individual's Qualified Health Plan selection.

(a) For a Qualified Health Plan selection received from the first (1st) through the fifteenth (15th) day of any month, the Effective Date will be the first (1st) day of the following month; and

(b) For a Qualified Health Plan selection received from the sixteenth (16th) through the last day of any month, the Effective Date will be the first (1st) day of the second following month.]

E. [**Changes Affecting Eligibility and Special Enrollment Periods.**

(1) Special Enrollment Triggering Events. A Special Enrollment Period is a period during which an eligible individual who experiences certain triggering events or changes in eligibility may enroll in this Contract, outside of the Open Enrollment period.

(2) Length of Special Enrollment Period. Unless otherwise stated, an eligible individual has 60 days from the date of a triggering event to enroll an eligible individual in this Contract.

(3) Triggering Events

(a) Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, misrepresentation of a material fact or failure to pay premium.

(b) Loss of Minimum Essential Coverage due to dissolution of marriage.

(c) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Indiana Marketplace.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to new service area of the Indiana Marketplace.

(h) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.]

F. Adding New Dependents Under A Special Enrollment Period

(1) Newly Born Children. If you have a new Dependent as a result of birth, coverage for your new Dependent is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for your new Dependent shall continue beyond the initial thirty-one (31) days, provided you [request a Special Enrollment Period through the Indiana Marketplace to add your new Dependent to this Contract] [submit a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, if any[, within 60 days after the birth of the new Dependent]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days after the date of birth. The Effective Date will be the date of birth.]

(2) Adopted Children. If you have a new Dependent as a result of adoption, coverage for your new Dependent is automatically provided from the earlier of

the date of placement for the purpose of adoption or the date of the entry of an order granting you custody of the child for purposes of adoption, for up to thirty-one (31) days. Coverage for your new Dependent shall continue beyond the initial thirty-one (31) day period provided you [request a Special Enrollment Period through the Indiana Marketplace to add your new Dependent to this Contract] [submit a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, in any[, within 60 days following the date of adoption or placement for adoption]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of adoption or placement of adoption.] The Effective Date will be the earlier of the date of adoption or placement of adoption.

(3) Adding a Child due to Award of Guardianship. If you or your spouse files an application for an appointment of guardianship for a Child, an application to cover the Child under this Contract must be submitted to [the Indiana Marketplace] [us] within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

(4) Qualified Medical Child Support Order. If you are required by a Qualified Child Support Order or court order, as defined by applicable state and federal law, to enroll your Child under this Contract, and the Child is otherwise eligible for the coverage, [the Indiana Marketplace] [we] will permit your Child to enroll in this Contract, and we will provide the benefits of this Contract in accordance with the applicable requirements of such court order.

A Child's coverage under this provision will not extend beyond the Dependent attaining age 26. Any claims payable under this Contract will be paid, at our discretion, to the Child or the Child's custodial parent or legal guardian, for any expenses paid by the Child, custodial parent or legal guardian. We will make information available to the Child, custodial parent or legal guardian on how to obtain benefits and submit claims to us directly.

(5) Spouse or Loss of Minimum Essential Coverage. If you have a new Dependent as a result of marriage, or due to your new Dependent's loss of Minimum Essential Coverage, you may elect to enroll your new Dependent in this Contract, provided you [request a Special Enrollment Period from the Indiana Marketplace to add your new Dependent to this Contract] [submit to us a form to add your new Dependent] and we receive payment for additional applicable premium, if any[, within 60 days from the date of marriage or the loss of Minimum Essential Coverage]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of marriage or the loss of Minimum Essential Coverage.] The Effective Date will be on the first (1st) day of the month following the date of marriage or loss of Minimum Essential coverage.

(a) "Loss of Minimum Essential Coverage" includes loss of eligibility for coverage as a result of any of the following:

(a) Legal separation or divorce.

(b) Cessation of dependent status (such as reaching the maximum age to be eligible as a Dependent under this Contract).

(c) Death of an employee; termination of employment; reduction in the number of hours of employment; or any loss of eligibility for coverage after a period that is measured by any of the foregoing.

(d) Individual who no longer resides, lives or works in the service area.

(e) A situation in which a health benefit plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Termination of employer contributions.

(g) Exhaustion of COBRA continuation of coverage.

(b) "Loss of Minimum Essential Coverage" does not include termination or loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(b) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact

If you do not enroll your new Dependent during the time periods stated above, he or she will not be added to your coverage until the next Open Enrollment Period.

G. Notification of Changes.

(1) Responsibility to Notify [the Indiana Marketplace] [Us]. You are required to notify [the Indiana Marketplace] [us] of any changes in your eligibility or the eligibility of your Dependents for Benefits under this Contract. [The Indiana Marketplace] [We] must be notified of any changes in eligibility as soon as possible, but not later than thirty (30) days from the date of the change in eligibility status. This may include changes in address, marriage, divorce, death, incarceration, change of Dependent disability or dependency status, change in Medicare or Medicaid eligibility status, etc. Notice of a change in eligibility must be provided to [the Indiana Marketplace in a form required and approved by the Indiana Marketplace] [us in writing and on a form approved by us]. Such notifications must include all information required to effectuate all necessary changes.

(2) Failure to Notify [Indiana Marketplace] [Us]. Failure to notify [the Indiana Marketplace] [us] of persons no longer eligible for coverage under this Contract will not obligate us to provide services to those no longer eligible. Our acceptance of payments for persons no longer eligible for services will not obligate us to pay for such services.

(3) Effective Date of Termination Due to Change in Eligibility. Regardless of whether we receive timely notice, a Covered Person's coverage will terminate on the [last day of the month following the date] [day] such Covered Person ceases to be eligible for coverage under this Contract. [We have the right to bill you for the cost of any Health Care Services provided to a Covered Person during the period such Covered Person is not eligible under this Contract.] If you think there are reasons coverage of the person experiencing the change should continue, you must notify [the Indiana Marketplace] [us] of the reasons for the continuation of the coverage no later than thirty-one (31) days after the date coverage for the Dependent would otherwise terminate.

(4) [Statements and Forms. You shall complete and submit to us applications and other forms or statements we may request. You represent to the best of their knowledge and belief that all information contained in such applications, forms, questionnaires, and statements submitted to us is true, correct and complete. You understand that all rights to Benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you or a Covered Person may result in termination or rescission of coverage.]

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A. Premium

(1) You must pay premium to us each month for coverage under this Contract. Your premium rate is determined using the following acceptable rating factors: age, tobacco use, family size and geography.

(a) Tobacco use impacts the determination of your premium. [Upon enrollment through the Indiana Marketplace] [During the enrollment application process], you will attest to tobacco use by you and/or your Dependents. If you report false or incorrect information about tobacco use, we may retroactively apply the appropriate tobacco rating factor to your premium as if the correct information had been accurately reported from the Effective Date.

(b) Your age impacts the determination of your premium rate. If your age has been misstated, we will adjust the premiums to the amount premiums would have been if purchased at the correct age.

(2) You will receive a monthly bill for your premium. Your payment is due by the date stated in your bill subject to the any applicable Grace Period stated in this Contract. You must pay your premium when it is due for coverage to continue.

(3) We reserve the right to change the premium on an annual basis. We will provide you with thirty (30) days prior written notice of any change in the premium.

(4) Your premium may change if Dependents are enrolled or disenrolled in your coverage. If a premium increase is necessary, we will bill you for the additional amount due. If this amount is not paid, this Contract will be cancelled at the end of the applicable Grace Period and you will receive a refund of any unearned premium. If a decrease in premium is appropriate we will notify you of the decrease and refund any excess premium to you.

(5) If premium has been paid for any period of time after the date you cancel this Contract, we will refund that premium to you. The refund will be for the period of time after your coverage ends. If a Covered Person dies while this Contract is in force, we will refund any premium paid for such Covered Person for any period after the date of the Covered Person's death to you or your estate.

B. Grace Period

(1) [General Grace Period.] Following payment of the initial premium, a Grace Period of thirty (30) days shall be granted for the payment of any premium. This Grace Period shall not extend beyond the date this Contract terminates. During the Grace Period this Contract shall continue in force. Any claims incurred and submitted during the Grace Period will not be considered for payment until premium is received. If premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of coverage.

(2) [Grace Period for Persons Receiving Advance Payments of the Premium Tax Credit. If you are receiving advance payments of the premium tax credit and at least one full month's premium has been paid during this Plan Year, a Grace Period of three (3) consecutive months shall be granted for the payment of any premium. During this 3-month Grace Period, we shall do all of the following listed below.

(a) Pay for Covered Services during the first (1st) month of the Grace Period and may pend claims for Covered Services rendered to you in the second and third months of the Grace Period.

(b) Notify the Department of Health and Human Services of such non-payment

(c) Notify Providers of the possibility for denied claims during the second and third months of the Grace Period.]

C. Deductible.

(1) The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The Deductible is set forth in the Schedule of Benefits.

(2) Copayments do not count towards the Deductible.

D. Coinsurance

(1) Coinsurance is a percentage of the Allowed Amount that you must pay for Covered Services. You are responsible for payment of Coinsurance after you have met the Deductible and until you reach the Out of Pocket Maximum. Coinsurance is set forth in the Schedule of Benefits.

(2) Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

E. Copayments

(1) Copayments are a fixed amount you pay to a Provider for a Covered Service. Copayments are typically paid when you receive the Covered Service. The amount of the Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

(2) Copayments do not apply to the Deductible. Copayments apply towards the Out of Pocket Maximum.

F. Out of Pocket Maximum

(1) The Out of Pocket Maximum is the maximum amount you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum is listed on the Schedule of Benefits.

(2) Once the Out of Pocket Maximum is reached, we will pay 100% of the Benefits for Covered Services.

(3) Copayments, Coinsurance and the Deductible apply towards the Out of Pocket Maximum.

G. Payments for Non-Covered Services. You are responsible for payment of all expenses for Non-Covered Services.

ARTICLE 4. COVERED SERVICES

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides Benefits for the following Covered Services. Payment for Covered Services is limited by any applicable Coinsurance, Copayment, or Deductible set forth in this Contract including the Schedule of Benefits. To receive maximum Benefits for Covered Services, you must follow the terms of this Contract, including receipt of care from a Primary Care Physician and Participating Providers as well as obtaining any required Precertification.

You are responsible for all expenses incurred for Non-Covered Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

A. Ambulance Services

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

(a) From your home, scene of accident or medical Emergency to a Hospital,

(b) Between Hospitals,

(c) Between a Hospital and Skilled Nursing Facility, or

(d) From a Hospital or Skilled Nursing Facility to your home.

(2) Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

(3) Other vehicles which do not meet the definition of Ambulance Services are not Covered Services. Ambulette services are Covered Services when appropriate.

(4) Ambulance Services are a Covered Service only when Medically Necessary, except:

(a) When ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse, or

(b) When a Covered Person is required by us to move from a Non-Participating Provider to a Participating Provider.

(5) Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health.

(6) Non-Covered Services for Ambulance include but are not limited to:

(a) A trip to a physician's office or clinic,

(b) A trip to a morgue or funeral home, or

(c) Any ambulance usage for the convenience of a Covered Person, family or Provider.

B. Behavioral Health Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Covered Services include:

(a) Inpatient services. Individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

(b) Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

(c) Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health conditions. Intensive Outpatient programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient programs may offer group, DBT, individual, and family services.

(d) Outpatient Treatment, or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

(2) Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

(3) To assist you in obtaining appropriate and quality care, we will ask for a treatment plan after you have been evaluated after 10 Outpatient visits. We may discuss the goals of treatment and changes in the treatment plan, including

alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

(4) Non-Covered Services include the following.

(a) Custodial or domiciliary care.

(b) Supervised living or halfway houses.

(c) Services or care provided or billed by a residential treatment center, school, halfway house.

(d) Custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(e) Services related to non-compliance of care if the Covered Person ends treatment for substance abuse against the medical advice of the Provider.

C. Routine Care Costs as Part of a Cancer or Other Life Threatening Disease or Condition Clinical Trial

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits are available for Routine Care Costs rendered as part of an Approved Clinical Trial if the services are otherwise Covered Services under this Contract.

(2) Your Primary Care Physician must give us notice of your participation in an Approved Clinical Trial.

(2) Non-Covered Services include the following.

(a) A Health Care Service that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient.

(b) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service or investigational drug that is the subject of the clinical trial.

(c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.

(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the clinical trial.

(e) An item or drug provided by the clinical trial sponsors free of charge for any patient.

(f) A service, item, or drug that is eligible for reimbursement by a person or entity other than us, including the sponsor of the clinical trial.

D. Dental Services Related to an Injury

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient services, Physician Home Visits and Office Services, Emergency Services and Urgent Care Center Services for dental work and oral surgery are Covered Services if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Covered Person's condition.

(2) Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

(3) For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

(4) Covered Services include, but are not limited to the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations
- Prosthetic services
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia

(5) Anesthesia and Hospital charges for dental care for a Covered Person less than 19 years of age or a Covered Person who is physically or mentally disabled, are covered if the Covered Person requires dental treatment to be given in a Hospital or Outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Covered Person's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

E. Diabetic Equipment, Education and Supplies

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when ordered in writing by a physician or a podiatrist and provided by a physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

(2) Covered Services include physician prescribed equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances”, “Preventive Care Services”, and “Physician Home Visits and Office Services”.

F. Diagnostic Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services include the following.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).

- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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

(3) For Diagnostic services other than those approved to be received in a physician's office, you may be required to use a laboratory that is a Participating Provider.

(4) When Diagnostic radiology is performed in a Participating Provider's Office, no Copayment is required, however, any Coinsurance will still apply.

G. Emergency Care Services and Urgent Care Center Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit limitation. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits for treatment of an Emergency Medical Condition and Emergency screening and stabilization services without Precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions.

(2) Benefits for Emergency Care include facility costs and physician services, supplies and Prescription Drugs charged by that facility.

(3) Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Copayment or Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify us or verify that your physician has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary. If your Provider is a Non-Participating Provider, you will be financially responsible for any care we determine is not Medically Necessary.

(4) Often an urgent rather than an Emergency Medical Condition exists. An urgent medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Such medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Primary Care Physician prior to receiving care for an urgent medical problem and your Primary Care Physician

authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Care Services.

H. Home Care Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Covered Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Care Services.
- Nutritional Guidance.
- Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Health Care Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Care Services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services in the home (except for Massage, Music, and Manipulation Therapy). Home Care visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

(3) Non Covered Services include the following.

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

(4) Home infusion therapy will be paid only if you obtain Precertification. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

I. Hospice Services

For all Covered Services, see the schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit limitations. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) 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 (6) months or less, as certified by the attending physician and hospice medical director. Covered Services will continue if the Covered Person lives longer than six (6) months, provided the hospice medical director or other hospice physician recertifies that the Covered Person is terminally ill.

(2) Covered Hospice Services include the following.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Care Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

(3) Non-Covered Services include services provided by volunteers and housekeeping services.

J. Inpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Inpatient services include the following.

(a) Charges from a Hospital, Skilled Nursing Facility or other Provider for room, board and general nursing services.

(b) Ancillary services.

(c) Professional services from a physician while an Inpatient.

(2) Room, Board, and General Nursing Services include either of the following.

(a) A room with two or more beds or a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

(b) A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

(3) Ancillary (Related) Services include any of the following.

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

(4) Professional Services include the following.

- Medical care visits limited to one visit per day by any one physician.
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, and EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

(5) When a Covered Person is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

K. Maternity Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

(2) If the Covered Person is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider for the Health Care Services to be Covered Services. If the Covered Person is pregnant on her Effective Date and is in her second or third trimester of pregnancy, she may receive Benefits for Health Care Services from a Non-Participating Provider if she requests and receives written approval from us.

(3) If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance or Copayment.

(4) If Maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

(5) Coverage for the Inpatient postpartum stay for a Covered Person and her newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if both or the following are met.

(a) In the opinion of your attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the following.

- The antepartum, intrapartum, and postpartum course of the mother and infant.
- The gestational stage, birth weight, and clinical condition of the infant.
- The demonstrated ability of the mother to care for the infant after discharge.
- The availability of post discharge follow-up to verify the condition of the infant after discharge.

(b) The mother of the newborn child agrees with the recommendation for a shorter length of stay.

(6) Covered Services include at-home post-delivery care visits at your residence by a physician or nurse performed no later than 48 hours following discharge from the Hospital. Coverage for this visit includes, but is not limited to parent education, assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At your discretion, this visit may occur at the physician's office.

(7) Covered Services include the following tests and examinations given at the earliest feasible time to the newborn child for the detection of the following disorders.

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

L. Medical Supplies, Durable Medical Equipment and Appliances

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Medical and Surgical Supplies. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a physician's office, including but not limited to, Depo-Provera and Remicade. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

(a) Covered Services include the following.

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.

- Clinitest.
- Needles/syringes.
- Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not Covered Services.

(b) Non-Covered Services include the following.

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Medijectors.

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

(3) Durable Medical Equipment - The rental (or, at our option, the purchase) of Durable Medical Equipment prescribed by a Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples of Durable Medical Equipment include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price.

(a) We will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Covered Person, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is a Covered Service.

(b) Covered Services include the following.

- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pump for IV fluids and medicine.
- Glucometer.

- Tracheotomy tube.
- Cardiac, neonatal and sleep apnea monitors.
- Augmentive communication devices are Covered Services when we approve based on the Covered Person's condition.
- CPAP machines when indicated for sleep apnea.

(c) Non-Covered Services include the following.

- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats.
- Rental of equipment if the Covered Person is in a Facility that is expected to provide such equipment.
- Translift chairs.
- Treadmill exerciser.
- Tub chair used in shower.

(4) Prosthetics. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

(a) Prosthetic devices should be purchased not rented. Applicable taxes, shipping and handling are Covered Services.

(b) Covered Services include the following.

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Plan Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction

is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered Services. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be a Covered Service.

- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Plan Year).

(c) Non-Covered Services include the following.

- Dentures, replacing teeth or structures directly supporting teeth.
- 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.

(5) Orthotic Devices. The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered Services. The casting is a Covered Service when an orthotic appliance is billed with it, but not if billed separately.

(a) Covered Services include the following.

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

(b) Orthotic appliances may be replaced one time per Plan Year unless specifically approved in writing by us. Additional replacements will be allowed for Covered Persons under age 18 due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

(c) Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

(d) Non-Covered Services include the following.

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

(6) Prosthetic limbs & Orthotic custom fabricated brace or support. Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be a Covered Service if they are determined by your physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities, and are not solely for comfort or convenience.

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

(b) Prosthetic limbs and orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

(7) Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below, as approved by us.

(a) The repair, adjustment or replacement of the purchased equipment, supply or appliance is a Covered Service if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.

- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

(b) Replacement of purchased equipment, supplies or appliance may be a Covered Service if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

(c) Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

M. Outpatient Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital or other facility as determined by us. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation.

(2) Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to Article 3 Section B for Behavioral Health Services covered by this Contract.

(3) Professional charges only include services billed by a physician or other professional.

(4) When Diagnostic Services or other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Service, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

(5) For Emergency Care refer to the section titled Emergency Services.

N. Autism Spectrum Disorder Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Autism Spectrum Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(2) Coverage is provided for the treatment of Autism Spectrum Disorders, including behavioral therapies such as Applied Behavior Analysis (ABA). Benefits are limited to Health Care Services prescribed by your physician in accordance with a treatment plan. Coverage for Health Care Services will be provided as prescribed by your treating physician in accordance with the treatment plan.

(3) Any exclusion or limitation in this Contract in conflict with the coverage described in this section will not apply.

(4) Coverage for Autism Spectrum Disorders will not be subject to limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Contract.

O. Physician Home Visits and Office Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service a Health Care Service must be Medically Necessary.

(1) Covered Services include care provided by a physician, including employees of the physician such as an advanced practice nurse or physician assistant, in his/her office or your home. Refer to the sections titled Preventive Care, Maternity Care, Home Care Services, and Behavioral Health Care Services for services covered by this Contract. For Emergency Care refer to the Emergency Services section.

(2) Office visits for medical care and consultations to examine, diagnose, and treat a Sickness or injury performed in the physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a physician's office, no Copayment is required however Coinsurance will apply.

(3) Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

(4) Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

(5) Surgery and surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

(6) Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a physician or other professional Provider.

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

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

(2) Preventive Care Services in this section shall meet requirements as determined by federal and state law.

(a) Health Care Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF. Covered Services include the screenings for following.

- Breast cancer.
- Cervical cancer.
- Colorectal cancer.
- High Blood Pressure.
- Type 2 Diabetes Mellitus.
- Cholesterol.
- Child and Adult Obesity.
- For Covered Persons age 15 – 65 and other ages at increased risk, Human Immunodeficiency Virus (HIV)
- Depression for adults
- Screening for alcohol misuse

(b) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(c) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Well Baby visits and care.
- Newborn screening for hearing
- Lead screening for children at risk for exposure
- Depression screening for adolescents

(d) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Women's contraceptives, sterilization procedures, and counseling. This includes generic drugs only, unless there is no generic equivalent, obtained from a Participating Pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms and intrauterine devices (IUDs) are also covered. When generic equivalents are available, prescription brand name contraceptives will not be covered under the Preventive Care benefit. Instead, prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the Prescription Drug Benefits section.
- Breastfeeding support, supplies, and counseling.
- Gestational diabetes screening.

(3) Covered Services also include the following services required by state law:

(a) Breast Cancer Screening. The following are Covered Services.

(a) If the female Covered Person is at least 35 years of age, one (1) baseline breast cancer screening mammography performed before she becomes 40 years of age.

(b) If the female Covered Person is less than 40 years of age and is high risk, one (1) breast cancer screening mammography performed every year. A woman is considered "high risk" if she meets at least one (1) of the following.

(A) Has a personal history of breast cancer.

(B) Has a personal history of breast disease proven benign by biopsy.

(C) Has a mother, sister, or daughter who has had breast cancer.

(D) Is at least 30 years of age and has not given birth.

(c) Any additional mammography views that are required for proper evaluation.

(d) Ultrasound services, if determined Medically Necessary by the physician treating the Covered Person.

(b) Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Service for a Covered Person under the age of fifty (50) if the Covered Person is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsymptomatic Covered Person, in accordance with the current American Cancer Society guidelines.

(c) Diagnostic Prostate Cancer Screening. If male Covered Person is at least 50 years of age, one (1) prostate specific antigen test annually is a Covered Service. If a male Covered Person is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test annually is a Covered Service.

Q. Surgical Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes the following.

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

(2) The surgical fee includes normal post-operative care.

(3) We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact us for more information.

(4) Covered Surgical Services include the following.

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

R. Reconstructive Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

(2) Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract.

(3) Covered Services are limited to the following.

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

(4) For a Covered Person who has undergone a mastectomy Covered Services include the following.

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

S. Sterilization.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

Sterilization is a Covered Service.

T. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

(2) Covered Services include removable appliances for repositioning and related surgery, medical care, and diagnostic services.

(3) Non-Covered Services include the following:

- Fixed or removable appliances that involve movement or repositioning of the teeth.
- Repair of teeth (fillings).
- Prosthetics (crowns, bridges, dentures).

U. Therapy Services.

Benefits are provided for therapy services that can be Rehabilitative or Habilitative. For purposes of this section and the Schedule of Benefits, the following definitions apply:

- Rehabilitation refers to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech therapy and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Physical therapy.

(a) Physical therapy includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve

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

(b) Non-Covered Services include the following.

-
- 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.

(3) Speech Therapy. Speech therapy for the correction of a speech impairment.

(4) Occupational Therapy. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

(a) Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

(b) Non-Covered Services include the following.

- Supplies (looms, ceramic tiles, leather, utensils).
- Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again.
- General exercises to promote overall fitness and flexibility.
- Therapy to improve motivation.
- Suction therapy for newborns (feeding machines).
- Soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial.
- Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

(5) Manipulation Therapy. Manipulation Therapy includes osteopathic/chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

(a) Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any limitation for Manipulation Therapy services as specified in the Schedule of Benefits.

(b) Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

(6) Other Therapy Services

(a) Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

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

(c) Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage this Contract will not require you to receive dialysis treatment at a Participating Provider that is a dialysis facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Participating Dialysis Facility is more than 30 miles from your home, you may, upon our prior written consent, receive treatment at a Non-Participating Provider that is a dialysis facility nearest to your home as Covered Service.

(d) Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

(e) Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to:

- Introduction of dry or moist gases into the lungs.
- Nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication.
- Continuous positive airway pressure ventilation (CPAP).
- Continuous negative pressure ventilation (CNP).
- Chest percussion.
- Therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers.
- Broncho-pulmonary drainage.
- Breathing exercises.

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

V. Physical Medicine and Rehabilitation Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

(2) The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting. Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

(3) Non-Covered Services include the following.

- Admission to a Hospital mainly for physical therapy.
- Long term rehabilitation in an Inpatient setting.

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

W. Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Cost Sharing.

(2) "Covered Transplant Procedure" includes any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

(3) "Transplant Benefit Period" starts one day prior to a covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Procedure and continues to the date of discharge at a Non-Participating Provider Facility.

(4) Transplant services require Precertification.

(5) Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are a Covered Service as routine Diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

(6) Transportation and Lodging. This Contract will provide assistance with reasonable and necessary travel expenses as determined by us when you obtain Precertification and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when claims are filed.

(7) Non-Covered Services for transportation and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

X. Prescription Drug Benefits

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Pharmacy Benefits Manager (PBM).

(a) The Prescription Drug benefits are managed by our Pharmacy Benefits Manager or PBM. The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy, a Specialty Pharmacy, and provides clinical management services. The management and other services the PBM provides include, making recommendations to, and updating, the "covered Prescription Drug list" (the "covered Prescription Drug list" is referred to as the "Formulary"), managing a network of retail pharmacies, operating a mail service pharmacy, and operating a Specialty Pharmacy network.

(b) The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of Prescription Drug benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions or drug/pregnancy concerns. You may request a copy of the Formulary by calling the Customer Service telephone number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage.

(c) For certain Prescription Drugs, the prescribing Provider may be asked to provide additional information before the PBM and/or we can determine Medical Necessity. We may, in our sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer.

(d) Precertification may be required for certain Prescription Drugs (or the prescribed quantity of a particular Prescription Drug). At the time you fill a prescription, the Participating Pharmacy is informed of the Precertification requirement through the Participating Pharmacy's computer system. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee which is reviewed and adopted by us.

(e) For a list of the current Prescription Drugs requiring Precertification, please contact the Customer Service telephone number on the back of your Identification Card or go to our website at [insert url to formulary]. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage. Your Provider or Participating Pharmacy may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under this Contract.

(2) Therapeutic Substitution of Prescription Drugs. This is a voluntary program designed to inform Covered Persons and Providers about possible substitutes to certain Prescription Drugs. We, or the PBM, may contact you and your prescribing Provider to make you aware of substitution options. Therapeutic substitutes may also be initiated at the time the Prescription Drug is dispensed.

(a) Only you and your Provider can determine whether the therapeutic substitute is appropriate for you.

(b) For questions or issues involving therapeutic substitutes, call the Customer Service telephone number on the back of your Identification Card.

(c) The therapeutic substitutes list is subject to periodic review and amendment.

(3) Step Therapy. Step therapy protocol means that a Covered Person may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Covered Persons access high quality yet cost effective Prescription Drugs. If a Provider decides that the monitored medication is needed the Precertification process is applied.

(4) Participating Specialty Pharmacy. The PBM's Specialty Pharmacy is available to Covered Persons who use Specialty Drugs.

(a) "Specialty Drugs" are Prescription Legend Drugs that are one of the following:

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

(b) Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, subject to a day supply limit for retail and mail service, and the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

(c) Questions regarding Specialty Drugs can be directed to the Customer Service telephone number on the back of your Identification Card.

(d) You may obtain a list of the Participating Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your Identification Card, or review the lists on our website at [insert address].

(5) Covered Services include the following.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Self-administered contraceptives, including oral contraceptives, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the Preventive Care section, please see that section for more details.
- Selected drugs to eliminate or reduce dependence on, or addiction to tobacco and tobacco products.
- Injectables.
- Selected preventive medications are covered with no Copayment or Coinsurance if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations. These medications include the following: vitamin D supplementation, folic acid supplementation, aspirin and oral fluoride supplementation.

(6) In addition to the Exclusions set forth in Article 4, Non-Covered Services include the following.

- Prescription Drugs dispensed by any mail service program other than the PBM's mail service pharmacy, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.

- Off label use, except as otherwise prohibited by law or as approved by us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription.
- Drugs not approved by the FDA except as otherwise prohibited by law.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a physician. This does not apply to drugs used in conjunction with a Diagnostic Service, with chemotherapy performed in the office or drugs eligible for coverage under the Medical Supplies benefit.
- Any drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by this Contract, or which exceed any age limits established by us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility drugs.
- Human growth hormone for children born small for gestational age.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact us for additional information on these Prescription Legend Drugs.
- Refills of lost or stolen medications.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, unless otherwise required by law or approved by us. "Clinically equivalent" means drugs that, for the majority of persons, can be expected to produce similar therapeutic outcomes for a disease or condition.

(7) If you have questions regarding whether a particular Prescription Drug is covered and which Tier a Prescription Drugs fall into, please call the Customer Service telephone number on the back of your Identification Card, or visit our website at [website address].

(8) Each Prescription Drug may be subject to a Deductible, Coinsurance or Copayment. If the prescription includes more than one covered Prescription Drug, a separate Coinsurance or Copayment will apply to each covered Prescription Drug. Your Copayment will be the lesser of your scheduled Copayment or the Allowable Amount.

(9) The number of days' supply of a Prescription Drug which you may receive is limited. The days' supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days' supply allowed for under this Contract, you should ask your Pharmacist

to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

(10) Your Copayment or Coinsurance amount may vary based on whether the Prescription Drug has been classified by us as a first, second, third, fourth or fifth "Tier" Prescription Drug. The determination of Tiers is made by us based upon clinical information, and where appropriate the cost of the Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

(a) Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This Tier will contain low cost and preferred generic medications as well as selected preventive medications that are covered with no Coinsurance or Copayment if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations.

(b) Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This Tier will contain non-preferred generic medications.

(c) Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This Tier will contain preferred brand name medications.

(d) Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This Tier will contain non-preferred brand name medications.

(e) Tier 5 Prescription Drugs will have a higher/comparative Coinsurance or Copayment than those in Tier 4. This Tier will contain medications that are considered Specialty Drugs.

We have established a Pharmacy and Therapeutics Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Precertification criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives. The Pharmacy and Therapeutics Committee also determines, where appropriate, the cost of a Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one drug over another in our patient program, and, where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by

mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

(11) From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, generic, mail service, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Prescription Drugs or preferred products for a limited period of time.

(12) The amount of Benefits paid is based upon whether you receive the Covered Services from a Participating Pharmacy, including a Participating Specialty Pharmacy, a Non-Participating Pharmacy, or the PBM's mail service program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug.

(13) How you obtain your Benefits depends upon whether you go to a Participating or a Non-Participating Pharmacy.

(a) Participating Pharmacy – Present your written prescription from your physician and your Identification Card to the pharmacist at a Participating Pharmacy. The Participating Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment or Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge and you believe the Prescription Drug should be covered, ask your pharmacist for an itemized receipt and submit it to us for reimbursement consideration.

(b) Specialty Drugs - You or your Provider can order your Specialty Drugs directly from a Participating Specialty Pharmacy, simply call the Customer Service telephone number on the back of your Identification Card. Your Specialty Drug may need Precertification prior to dispensing. Upon approval, your Specialty Drug will be delivered to your physician's office/your specified delivery location based on the physician's order. A clinician will be available to answer any questions you may have in regard to the Specialty Drug and the instructions.

(c) Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy, including a Non-Participating Specialty Pharmacy. You must submit a claim for reimbursement consideration as set forth in Article 8 Section C.

(d) The Mail Service Program – Complete the order and patient profile form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have your physician fax the prescription to the mail service pharmacy. Your physician may also phone in the prescription to the mail service pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the mail service pharmacy when you request a prescription.

(14) Drug Exception Program. This is a program designed to allow Covered Persons to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. Please call the Customer Service number on the back of your Identification Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or are currently undergoing a course of treatment using a Prescription Drug that is not on the Formulary, you may request an expedited review of your request for a drug exception. In such circumstances, we will provide you or your Designated Representative with our decision within twenty-four (24) hours after we receive your request.

Y. Pediatric Vision Services. The following Health Care Services are Covered Services only for Covered Person through the age of nineteen (19). The Contract only provides Benefits for vision care that is listed in this section.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A complete pediatric eye exam. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together. The exam may include the following.

- Case History.
- Cover test.
- Ocular Motility.
- Neurological Integrity.
- External Exam.
- Internal Exam.
- Retinoscopy.
- Phorometry testing.
- Point refraction.
- Tonometry.
- Opthalmoscopic exam.
- Confrontation Visual Fields.
- Biomicroscopy.
- Color Vision Testing.
- Diagnosis/Prognosis.
- Recommendations.

(2) Eyeglass Lenses. Lens options include a choice of plastic or polycarbonate. Lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include up to 55 mm in single vision, bifocal, trifocal or lenticular.

(3) Frames. This Contract offers a selection of frames that are covered.

(4) Contact Lenses. Coverage includes the following.

(a) Contact Lens professional fitting fees.

(b) Elective Contact Lenses (elective contact lenses are contacts that are chosen for comfort or appearance).

(c) Non-Elective Contact Lenses are only provided for the following medical conditions.

- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when the patient's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

(d) Medically Necessary contact lenses are available in lieu of ophthalmic lenses and may be subject to Copayments, Coinsurance and limitations. The Provider determines a patient's qualifying criteria at examination and evaluation, and will obtain any necessary Precertification from us for these services.

(5) Low Vision Benefits

(a) Comprehensive Low Vision Exam.

(b) Optical/Non-optical aids.

(c) Supplemental testing.

(6) Non-Covered Services include services incurred for, or in connection with, any of the items below.

- Non-elective contact lenses for any Covered Person who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- For safety glasses and accompanying frames.
- For Inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Covered Person has reached the normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Contract.

- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Vision services for Covered Persons over the age of nineteen (19) unless specifically stated in this Contract.

ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS

A. **Non-Covered Services**. This Article 5 sets forth services that are excluded from coverage under this Contract and therefore are Non-Covered Services. Non-Covered Services are not covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

B. **Exclusions**. The following are Non-Covered Services:

(1) Services that we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.

(2) Services received from an individual or entity that is not a Provider.

(3) Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.

(4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

(5) Services provided as benefits by any governmental unit, unless otherwise required by law or regulation.

(6) Services for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

(7) Services for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

(8) Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

(9) Court ordered testing or care unless Medically Necessary.

(10) Services for which you have no legal obligation to pay in the absence of this or like coverage.

(11) Charges for consulting with Covered Persons by telephone, facsimile, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Covered Person except as otherwise described in this Contract.

(12) Surcharges for furnishing and/or receiving medical records and reports.

(13) Charges for doing research with Providers not directly responsible for your care.

(14) Charges that are not documented in Provider records.

(15) Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.

(16) Administrative, or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

(18) Services prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

(19) Completion of claim forms or charges for medical records or reports unless otherwise required by law.

(20) Missed or canceled appointments.

(21) Mileage, lodging and meals costs, and other travel related expenses, except as authorized by us or specifically stated as a Covered Service in this Contract.

(22) Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.

(23) Services incurred prior to the Effective Date.

(24) Services incurred after the termination date of this coverage except as specified elsewhere in this Contract.

(25) For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Complications directly related to Cosmetic Services treatment or surgery, as determined by us, are not covered. This exclusion applies even if the original Cosmetic Services treatment or surgery was performed while the Covered Person was covered by another carrier/self-funded plan prior to coverage under this Contract. “Directly related” means that the treatment or surgery occurred as a direct result of the Cosmetic Services treatment or surgery and would not have taken place in the absence of the

Cosmetic Services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

(26) Maintenance Therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance Therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

(27) Custodial Care, convalescent care or rest cures.

(28) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

(29) Services provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

(30) Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

(31) Services or care provided or billed by a school, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(32) Wilderness camps.

(33) For routine foot care (including the cutting or removal of corns and calluses), Nail trimming, cutting or debriding, Hygienic and preventive maintenance foot care, including but not limited to 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.

(34) Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

(35) Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to the following.

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

(36) 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.

(37) Dental implants.

(38) Dental braces.

(39) Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following.

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer or cleft palate.

(40) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

(41) Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

(42) Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by us, are not covered. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(43) Marital counseling.

(44) Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

(45) Vision orthotic training.

(46) Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.

(47) Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

(48) Services to reverse voluntarily induced sterility.

(49) Diagnostic testing or treatment related to infertility.

(50) Personal hygiene, environmental control, or convenience items including but not limited to the following.

- Air conditioners, humidifiers, air purifiers.
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals.
- Charges for non-medical self-care except as otherwise stated.
- Purchase or rental of supplies for common household use, such as water purifiers.
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds.
- Infant helmets to treat positional plagiocephaly.
- Safety helmets for Covered Persons with neuromuscular diseases.
- Sports helmets.

(51) Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

(52) Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by us, or as otherwise described in this Contract.

(53) Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.

(54) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

(55) For self-help training and other forms of non-medical self-care, except as otherwise provided in this Contract.

(56) Examinations relating to research screenings.

(57) Stand-by charges of a Provider.

(58) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

(59) Services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

(60) Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Contract.

(61) Manipulation Therapy services rendered in the home as part of Home Care Services.

(62) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. This Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

(63) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

(64) Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

(65) Any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(66) Surgical treatment of gynecomastia.

(67) Treatment of hyperhidrosis (excessive sweating).

(68) Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by us through Precertification.

(69) Complications directly related to a service or treatment that is a Non-Covered Service under this Contract because it was determined by us to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

(70) Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

(71) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

(72) Treatment of telangiectatic dermal veins (spider veins) by any method.

(73) Reconstructive services except as specifically stated in this Contract or as required by law.

(74) Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

(75) For non-preventive medical nutritional therapy.

(76) Abortions that are not Therapeutic Abortions.

C. Experimental/Investigative Health Care Services Exclusion. We do not provide coverage for any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be Experimental/ Investigative.

(1) 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.

(a) 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 granted.

(b) Has been determined by the FDA to be contraindicated for the specific use.

(c) Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

(e) 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.

(2) Any Health Care Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by us. In determining whether a Health Care Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

(a) The scientific evidence is conclusory concerning the effect of the Health Care Service on health outcomes.

(b) The evidence demonstrates the Health Care Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects.

(c) The evidence demonstrates the Health Care Service has been shown to be as beneficial for the total population for whom the Health Care Service might be proposed as any established alternatives.

(d) The evidence demonstrates the Health Care Service has been shown to improve the net health outcomes of the total population for whom the Health Care Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(3) Off-Label Drug Treatment. Coverage for a drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

(a) The drug is recognized for treatment of the indication in at least one standard reference compendium.

(b) The drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have

been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the drug's use to be contraindicated or the drug has not been approved by the FDA for any indication.

(4) The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

(a) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.

(b) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.

(c) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Documents of an IRB or other similar body performing substantially the same function.

(e) Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(f) Medical records.

(g) The opinions of consulting Providers and other experts in the field.

ARTICLE 6. OBTAINING COVERED SERVICES

A. Participating Providers.

(1) Unless otherwise specifically provided in this Contract, in order to receive Benefits under this Contract, a Covered Person must receive Covered Services from a Participating Provider.

(2) The Covered Person is responsible for verifying that a Provider is a Participating Provider. A list of Participating Providers is available online at [insert website] or by calling us at [toll free number].

B. Non-Participating Providers. Health Care Services received from Non-Participating Providers are Non-Covered Services except for the following circumstances.

(1) Emergency Health Care Services.

(a) If we determine that the Health Care Services were not an Emergency, the Health Care Services are Non-Covered Services and you will be responsible for costs associated with the Health Care Services.

(b) Subsequent follow up care by a Non-Participating Provider after the condition is no longer an Emergency is a Non-Covered Service unless specifically authorized by us.

(c) If a Covered Person is hospitalized in a Non-Participating Hospital due to an Emergency, you or the Provider must notify us within 48 hours of the admission. A continued stay after the condition is stabilized and is no longer an Emergency requires our written authorization. We may elect to transfer the Covered Person to a Participating Hospital once it is medically appropriate to do so.

(2) Non-emergency Medically Necessary Health Care Services that cannot be provided by a Participating Provider and for which the Covered Person has obtained a Referral from his/her Primary Care Physician.

(3) Maternity services for a Covered Person who was in her second or third trimester of pregnancy as of her Effective Date as provided in Article 3 Section K.

(4) When our agreement with a Participating Provider terminates, upon your written request, you may continue to receive Covered Services from the Provider for the following time periods.

(a) Up to sixty (60) days.

(b) In the case of Covered Person who is pregnant and in the third trimester of pregnancy, you may continue to receive Covered Services through the term of the pregnancy.

(c) For a Covered Person who is hospitalized until the Covered Person is discharged from Inpatient status.

C. Primary Care Physician.

(1) You must designate a Primary Care Physician for each Covered Person. If you do not select a Primary Care Physician we will assign one.

(2) The Covered Person's Primary Care Physician will be responsible for coordinating Covered Services and making referrals to other Participating Providers. A Covered Person does not need a referral from his/her Primary Care Physician for obstetrical or gynecological treatment from a Participating Provider. A Covered Person may seek care directly from an obstetrician or gynecologist that is a Participating Provider. For all other Providers, the Covered Person must obtain a referral from his/her Primary Care Physician to obtain benefits for Covered Services under this Contract.

(3) You may change the selection of a Primary care Physician no more frequently than once each month. A Covered Person may change his/her Primary Care Physician by submitting a written request, online at [insert website address], or by contacting us at the number shown on your Identification Card. A change in Primary Care Physician selection will be effective no later than thirty (30) days from the date we receive a request.

ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES AND GRIEVANCE PROCEDURES.

This Article 7 sets forth the procedures for requesting approvals for Covered Services from us as well as general Grievance procedures.. In processing claims, we review requests for Precertification, Predetermination, and Post Service Clinical Claims Review to determine whether provided or proposed to be provided Health Care Services are Covered Services. Health Care Services must be Medically Necessary for Health Care Services to be considered Covered Services.

A. Covered Service Review Requests

(1) Types of Covered Service Review Requests.

(a) Precertification – 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.

(b) Predetermination – An optional, voluntary prior or concurrent request for a benefit coverage determination for a Health Care Service. We will review your Contract to determine if there is an Exclusion for the service or treatment requested. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service or treatment meets our definition of Medical Necessity, or if it is Experimental/Investigative as that term is defined in this Contract.

(c) Post Service Clinical Claims Review – A retrospective review (Post-Service) for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Precertification and did not undergo a Predetermination review. Post Service Clinical Claims Reviews are done for Health Care Services for which we have a related clinical coverage guideline and are typically initiated by us.

(2) Most Participating Providers know which Health Care Services require Precertification and will get Precertification or ask for Predetermination from us as needed. Your Primary Care Physician and all other Participating Providers have received information from us on the procedures for requesting approvals for Covered Services and are responsible for meeting the requirements under such procedures. Generally, the Participating Provider ordering the service, treatment or admission will contact us to ask for Precertification or Predetermination reviews ("Requesting Provider"). We will work directly with your Requesting Provider regarding such review requests; however, your Designated Representative may act on your behalf throughout the review process.

(3) We will utilize our clinical coverage guidelines, including internally developed guidelines, procedures, and preventative care clinical coverage guidelines, to help us determine whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions Identified

as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

(4) You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact us at [toll free number].

B. Review Request Categories.

(1) Urgent Care – A request for Precertification or Predetermination that in the view of your attending Provider, or any physician with knowledge of your medical condition, could seriously jeopardize your life or health or your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Urgent Care Claim.

(2) Pre-Service – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

(3) Concurrent Care – A request for Precertification or Predetermination that is conducted during an ongoing course of treatment or admission. If we have approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by us of such course of treatment before the end of such period of time or number of treatments shall constitute a benefit determination adverse to you. We will notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination before the benefit is reduced or terminated.

(4) Post-Service – A request for approval that is made after the service, treatment or admission has occurred. Post-Service review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

C. Benefit Decision and Notice Requirements.

(1) We will resolve benefit review requests according to the timeframes listed in the table below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws.

Request Categories	**Timeframe Requirement for Benefit Decisions and Notification**
Pre-Service Claim	15 calendar days from receipt of request
Pre-Service Urgent Care Claim	72 hours from receipt of request
Concurrent Care Claim	15 calendar days from receipt of

	request
Concurrent Urgent Care Claim	24 hours from receipt of request
Post-Service Claim	20 business days from receipt of request

D. Timeframe Extensions for Benefit Decisions and Notifications.

(1) Post-Service and Pre-Service Claims. If we are unable to complete our review due to circumstances beyond our control, we will notify you, your Designated Representative, and the Requesting Provider in writing within:

(a) Fourteen (14) days after our receipt of a Pre-Service claim review request, and

(b) Nineteen (19) days after our receipt of a Post-Service claim review request.

The written notice will include the reason for the delay, a list of any applicable additional information that we need from you in order to complete our review and a revised timeframe for the resolution. If the reason for the delay is because your review request lacked sufficient information to complete our review of your request, you, your Designated Representative and Requesting Provider will have forty-five (45) days from receiving our notice of delay to provide the necessary information. We will notify you, your Designated Representative and the Requesting Provider of our decision within not more than ten (10) days after notifying you, your Designated Representative and Requesting Provider of the reason for our delay or of our receipt of the necessary information or of the end of the period afforded to you to supply the necessary information, as applicable. If we do not get the specific information we need or if the information is not complete by the timeframe provided to you, we will make a decision based upon the information we have.

(2) Urgent Care Claims. If you fail to provide us with sufficient information to review your Urgent Care Claim review request, we will notify you as soon as possible, but not later than twenty-four (24) hours after our receipt of the claim, of the specific information necessary to complete our review. You will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. We will notify you, your Designated Representative and Requesting Provider of our decision as soon as possible, but in no case later than forty-eight (48) hours of the earlier of the following:

(a) our receipt of the necessary information, or

(b) the end of the period afforded to you to supply the necessary information.

If we do not get the specific information we need or if the information is not complete by the timeframe provided to you, we will make a decision based upon the information we have.

E. Denial of Experimental Treatment.

If we deny coverage for a treatment, procedure, drug or device on the grounds that the treatment, procedure, drug or device is experimental, we will provide you with a written explanation that includes the following information:

(a) The basis for the denial.

(b) Your right to Appeal our decision.

(c) Our telephone number that you may contact for assistance in initiating an Appeal of our decision.

(2) If your health situation is life threatening or is an emergency, you are entitled to a review of our decision to deny coverage on the grounds that the treatment, procedure, drug or device is experimental that takes not more than seventy-two (72) hours.

F. What is a Grievance. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(1) Availability, delivery, appropriateness, or quality of health care services.

(2) Handling or payment of claims for health care services.

(3) Matters pertaining to the contractual relationship between you and us.

G. Who May File.

(1) You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

(2) If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

H. How a Grievance May Be Filed.

(1) You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, including fax]

(2) A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

I. No Retaliation. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 7.

J. Grievance Procedure.

(1) Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

(2) Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

(3) Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

(4) Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

(5) Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

K. Appeals Procedure.

(1) Right to an Appeal.

(a) If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

(b) You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

(c) The Appeal may be expressed orally or in writing by contacting us at the address and phone number provided below.

[Address]

(d) We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

(2) Appeal Panel.

(a) We will appoint a panel of qualified individuals to resolve your Appeal (the "Appeal Panel"). The Appeal Panel will resolve your Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

(b) The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date and place during normal business hours for the Appeal Panel to meet to discuss your Appeal. You will be given seventy-two (72) hours advance notice of the date and time of the meeting.

(c) You or Your Designated Representative may:

(a) appear in person before the Appeal Panel; or

(b) communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

(d) You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

(e) To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

(f) The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

(g) If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:

(a) Has knowledge in the medical condition and Health Care Service;

(b) Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and

(c) Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with you or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.

(3) Appeal Decision and Notice of Decision.

(a) The Appeal Panel's decision regarding your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

(b) . The Appeal Panel will resolve Appeals according to the timeframes listed in the table below.

Appeal Categories	**Timeframe Requirement for Appeal Decisions and Notification**
Appeal of a Pre-Service Claim Decision	30 calendar days from our receipt of the Appeal
Appeal of a Pre-Service Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Concurrent Care Claim Decision	15 calendar days from our receipt of the Appeal
Appeal of a Concurrent Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Post-Service Claim Decision	45 calendar days from our receipt of the Appeal

(c) We shall notify you or your Designated Representative of our decision in writing regarding your Appeal within five (5) business days after we complete our investigation.

(4) Expedited Review of Internal Appeals.

(a) An Expedited Review of an internal Appeal may be initiated orally, in writing or by other reasonable means available to you, your Designated Representative or your Provider.

(b) Expedited Review is available only if your attending Provider believes that, based upon your medical condition, our standard internal Appeal procedure could seriously jeopardize your life or health or your ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed.

(c) Appeals of Urgent Care Claim decisions are referred directly to our Expedited Review procedure for investigation and resolution.

(d) We will complete our Expedited Review of your Appeal as soon as possible given the medical exigencies but no later than within 72 hours after our receipt of your request for Appeal.

(e) We will communicate our decision regarding your Appeal by telephone to you, your Designated Representative, and your attending Provider. We will also provide written notice of our decision to you, your Designated Representative and your attending Provider.

(f) An Expedited Review of Concurrent Urgent Care Claims and Pre-Service Urgent Care Claims may occur at the same time as an External Review (as described below).

L. External Review

(1) You or your Designated Representative may seek External Review if our decision regarding your Appeal upheld a decision that was adverse to you regarding any of the following.

(a) A Medically Necessary service.

(b) A utilization review decision.

(c) A determination that a proposed service is Experimental/Investigational.

(d) A decision to rescind your Contract.

If your Appeal did not involve one of the above adverse decisions, you are not entitled to an External Review.

(2) If you have the right to an External Review under Medicare (42 U.S.C. 1395, et seq.) you may not request an External Review of our Appeals decision under the procedures outlined in this Contract.

(3) If your situation qualifies, you or your Designated Representative must file a written request for an External Review with us within 120 days after you receive notice of our internal response to the Appeal.

(4) Independent Review Organization (IRO).

(a) If an External Review is requested, we will forward all information related to your External Review to an IRO selected from the list of IROs that are certified by the Indiana Department of Insurance.

(b) The IRO will make a determination to uphold or reverse our Appeal decision within seventy-two (72) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within fifteen (15) business days if the condition does not involve an Urgent Care Claim.

(c) The IRO will notify you and your Designated Representative of its decision within twenty-four (24) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within seventy-two (72) hours if the review does not involve an Urgent Care Claim.

(d) If the IRO decision reverses our Appeals decision, we will notify you, your Designated Representative or Provider in writing of the steps we will take to comply with the IRO's decision.

M. Important Contact Information and Notice to Covered Persons

(1) Questions regarding your coverage should be directed to: Indiana University Health Plans; [toll free number]

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

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

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

(3) Complaints can also be filed electronically at www.in.gov/idoi.The review procedures described in this Article 7 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

ARTICLE 8. PAYMENT FOR COVERED SERVICES

A. How to Obtain Benefits.

(1) Whenever you receive Health Care Services, you must provide the Provider with a copy of your Identification Card.

(2) When you receive Covered Services from a Participating Provider you are not required to file a claim. Since no claim filing is required, you are not required to follow the procedures outlined in Section C of this Article 8.

B. Who Receives Payment Under This Contract.

(1) We pay Benefits for your Covered Services directly to a Participating Provider.

(2) If you receive Covered Services from a Non-Participating Provider as provided in Article 6 Section B, we will pay Benefits to the Non-Participating Provider, unless you agreed to make payment to the Non-Participating Provider and are entitled to reimbursement for such payment.

C. Payment for Covered Services received from Non-Participating Providers.

(1) Time to File Claims. For Covered Services received from a Non-Participating Provider, written notice of a claim must be given to us, by you or the Non-Participating Provider, within thirty (30) days of the date the Covered Services began. Failure to furnish the claim within thirty (30) days will not invalidate or reduce any claim if submission within thirty (30) days was not reasonably possible, so long as the claim is submitted within a reasonable time.

(2) Claim Forms. We shall provide forms to you for filing Proof of Loss within fifteen (15) days of notice of any claim. If you do not receive the forms within fifteen (15) days, written notice of services rendered may be submitted to us without the claim form. Claim forms are available on our website at [website address].

(3) Proof of Loss. Proof of loss under this Contract must be furnished to us within ninety (90) days after the loss. Failure to furnish the claim within ninety (90) days will not invalidate or reduce any claim if submission within ninety (90) days after the loss was not reasonably possible, so long as the claim is submitted within one (1) year after the time required under this Contract unless you were legally incapacitated.

(4) Address. All correspondence regarding claims should be sent to us at:

Indiana University Health Plans
[Address]
[City/state/zip]
[Fax]

(5) Amount of Payment. Payment for Health Care Services received from a Non-Participating Provider will be the lesser of the following amounts.

(a) The usual, customary and reasonable charge for the Health Care Service;

(b) An amount agreed upon by us and the Non-Participating Provider.

D. Clean Claims.

(1) A clean claim is a claim submitted by a Provider for payment that has no defect. We shall pay or deny each clean claim as follows.

(a) If the claim is filed electronically, within thirty (30) days after the date we receive the claim.

(b) If the claim is filed on paper, within forty-five (45) days after the date we receive the claim.

(2) If we fail to pay or deny a clean claim in the time frames set forth above and subsequently pay the claim, we will pay the Provider that submitted the claim allowable interest in accordance with Indiana Code § 27-8-5.7-6.

ARTICLE 9. COORDINATION OF BENEFITS

This Article applies only if you also have other health benefits coverage with another Plan. The Definitions contained in this Article apply throughout this Article 9 but do not apply to the rest of the Contract.

A. **When you have other health benefits**. In the event that you are covered by two health insurance contracts, plans or policies ("Plans") providing similar benefits and you receive a Health Care Service that would be covered by both Plans, we will coordinate benefit payments with any payment made under the other Plan. One company will pay its full benefit as the Primary Plan. The other company will pay Secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments.

B. **Definitions**.

(1) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the Plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(2) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

(3) "Closed Panel Plan" means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in the case of emergency or referral by a panel Covered Person.

(4) "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(5) "Plan" means any of the following that provides benefits or services for medical treatment:

(a) Any group or blanket insurance contract, plan or contract, except that blanket school accident coverage or such coverage offered to

substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or contract.

(b) Any self-insured or noninsured Plan or any other Plan arranged through an employer, trustee, union, employer organization or employee benefit organization.

(c) Any coverage under governmental programs or any coverage required to be provided by any statute. However, Medicaid and any Plan whose benefits are, by law, excess to those of any private insurance plan or other nongovernmental plan shall not be considered health insurance policies.

(d) Group or nongroup coverage through Closed Panel Plans or group type contracts.

(e) Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional "fault" type contracts.

(6) "Primary" or "Primary Plan" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If the Plan is Primary to another Plan, the Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(7) "Secondary" or "Secondary Plan" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If the Plan is Secondary to another Plan, the Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

C. Rules To Determine Payment. When two or more Plans pay benefits, the rules for determining the order of payments are as follows:

(1) The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

(2) If the other Plan does not have a provision similar to this one, then it will be primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(3) A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. Order of Determination of Benefits Rules: The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent is Primary, for example as an employee, subscriber or retiree is

primary and the Plan that covers the person as a Dependent is Secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent; then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, subscriber or retiree is Secondary and the other Plan is Primary.

(2) Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods commencing after the Plan is given notice of the court decree.

(d) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(a) The Plan of the Custodial Parent.

(b) The Plan of the spouse of the Custodial Parent.

(c) The Plan of the non-Custodial Parent.

(d) The Plan of the spouse of the non-Custodial Parent.

(3) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is Primary. The same would hold true is a person is a Dependent of a person covered as a retiree or an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined Section (C)(1) of this Article 9.

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, subscriber or retiree (or as that person's Dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, subscriber or retiree longer is Primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid if it had been Primary.

E. Payment of the Benefit When This Plan is Secondary.

(1) When this Plan is Secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other Plan and this Plan do not exceed your expenses for an item of service. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by the Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

(a) Determine its obligation to pay or provide benefits under its Plan;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

(2) If there is a benefit reserve, the Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

(3) If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, Coordination of Benefits shall not apply between that Plan and other Closed Panel Plans.

F. Payments to others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid.

G. Our Right to Recover Overpayment. In some cases, we may have made payment even though you had coverage under another Plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the

payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other Plan. You agree to sign any document that we deem necessary to help us recover any overpayment.

ARTICLE 10. TERMINATION OF COVERAGE

A. [**Guaranteed Renewable.** As long as you continue to be a Qualified Individual and this Contract continues to be a Qualified Health Plan, you may renew this Contract at your option without regard to the health status of you or any Covered Person.]

[Guaranteed Renewable. Coverage under this Contract is guaranteed renewable at the discretion of the Subscriber, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, as described in this Article 10. You may renew this Contract at your option without regard to the health status of you or any Covered Person. You may renew this Contract by payment of the renewal premium by the end of the Grace Period of the premium due date, provided the following requirements are satisfied:

(1) Eligibility criteria outlined in Article 2 continues to be met.

(2) There are no fraudulent or intentional misrepresentations on the application or under the terms of this Contract.

(3) Coverage has not been terminated by us under the terms of this Contract.]

B. **Termination.** We may terminate this Contract or coverage of a Covered Person for the following reasons.

(1) You are no longer eligible for coverage [through the Indiana Marketplace].

(2) A Covered Person is no longer eligible under [the rules of the Indiana Marketplace or] the terms of this Contract.

(3) You do not pay premium and the applicable Grace Period has been exhausted.

(4) We receive a request from you to terminate the Contract.

(5) You commit an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact.

(6) You change coverage to another [Qualified Health Plan] [health plan] during the [Indiana Marketplace] Open Enrollment Period or a Special Enrollment Period.

(7) [The Contract is no longer a Qualified Health Plan or we are decertified by the Indiana Marketplace.]

(8) You no longer reside in our Service Area.

(9) We discontinue a particular product provided that we provide you with written notice at least ninety (90) days before the date the product will be discontinued, we offer you the option to purchase any other individual contract we currently offer, and we act uniformly without regard to any health status-related factor.

(10) We discontinue all contracts in the individual market in Indiana provided that we provide you and the Indiana Department of Insurance with written notice at least 180 days before the date of the discontinuance, we discontinue and do not renew

all contracts in the individual market in the State of Indiana, and we act uniformly without regard to any health status-related factor.

(11) We may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with the laws of the State of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

C. Effective Date of Termination. [Termination of this Contract automatically terminates all coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.]

(1) If you terminate this Contract or coverage for a Covered Person, the last day of coverage [will be on the last day of the billing period for which premium has been paid. A request for termination must be received by us in writing] [is:

(a) The termination date specified by you, if reasonable notice is provided;

(b) If you do not provide reasonable notice, fourteen (14) days after the termination is requested, or

(c) If you do not provide reasonable notice and request a termination date in less than fourteen (14) days, on a date determined by us if we are able to implement termination in fewer than fourteen (14) days.]

(2) [If newly eligible for Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.]

(3) [If you are no longer eligible for coverage through the Indiana Marketplace, the last day of coverage is the last day of the month following the date notice is sent to us by the Indiana Marketplace, unless you request an earlier termination effective date.] [If you move outside of the Service Area, the last day of coverage for you and all of your Dependents will be at the end of the billing period that contains the date you no longer resided in the Service Area.]

(4) [If a Covered Person is no longer eligible for coverage under the rules of the Indiana Marketplace or the terms of this Contact, the last day of coverage is the last day of the month following the date the Covered Person loses eligibility.] [If a Dependent no longer meets the definition of Dependent, the last day of coverage for the Dependent will be on the last day of the billing period in which we received notice of the Dependents loss of eligibility.]

(5) In the case of a termination for non-payment of premium and the applicable Grace Period has been exhausted, the last day of coverage [for all Covered Persons] will [be either the last day of the first month of the 3-month Grace Period or] the last day for which premium was paid.

(6) [In the case of a termination due to a change to another Qualified Health Plan, the last day of coverage is the day before the effective date of coverage in his or her new Qualified Health Plan.]

(7) The day following a Covered Person's death. When a Subscriber dies, the surviving spouse, if covered under the Contract, may receive an individual contract. The surviving spouse should contact [the Indiana Marketplace] [us] to identify the process for enrollment.

D. Notice of Termination.

(1) We shall provide you with written notice of our intent to terminate or not renew this Contract at least sixty (60) days prior to the effective date of the termination. This notice will identify the date upon which your coverage will terminate.

(2) Our notice to the Subscriber shall be deemed as notice to all Covered Persons and is sufficient if mailed to the Subscriber's address as it appears in our records.

(3) Termination of this Contract shall not prejudice any claim for Covered Services rendered before the effective date of the termination.

E. Continuation of Coverage.

(1) If we terminate this Contract, except for a termination due to our receivership, and a Covered Person is hospitalized for a medical or surgical condition on the effective date of the termination, coverage will continue for Inpatient Covered Services. Benefits shall end on the earliest of the following dates.

(a) The date the Covered Person is discharged from the Hospital.

(b) The date the Covered Person is covered under other health coverage if that coverage covers the Inpatient Hospital services.

(c) Sixty (60) days after the date this Contract ends.

(d) The last day the required premium has been paid if the Grace Period expires and the Subscriber has not made the required payment.

(e) The date the you terminate coverage.

(2) If this Contract terminates due to our receivership, coverage will continue for the following time period:

(a) The duration of the contract period for which premiums have been paid.

(b) If a Covered Person is hospitalized on the date of our receivership for the longer of the following time periods.

(A) The period ending when the Covered Person is discharged from the Inpatient hospitalization.

(B) The duration of the contract period for which premiums have been paid.

F. **Rescission.** If within two (2) years after the Effective Date of this Contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or a Covered Person did not disclose on your application, we may rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding your newly born children within 31 days of birth), we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or a Covered Person did not disclose on the application, we may rescind coverage for the additional Dependent as of his or her original Effective Date. Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by a Covered Person may result in termination or rescission of coverage. You are responsible to pay us for the cost of previously received services based on the Allowed Amount for such services, less any Copayments/Coinsurance paid or Premium paid for such services.

This Contract may also be terminated if you knowingly participate in or permit fraud of deception by any Provider, vendor or any other person associated with this Contract. Termination for any act, practice or omission that constituted fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give you at least thirty (30) days written notice prior to the rescission of this Contract.

G. **Reinstatement.** If your Contract was terminated for non-payment of premium, you may request reinstatement of the Contract from [the Indiana Marketplace] [us] within 30 days of the effective date of the termination. You must remit all premium that was due for the coverage upon reinstatement. Upon [notice from the Indiana Marketplace and] receipt of the outstanding premium, we will reinstate coverage as of the effective date of the termination.

H. [**Certification of Prior Creditable Coverage If Required by Law.** If your coverage is terminated, you and your Dependents will receive certification from us showing that you were covered under this Contract. You may need this certification document in order to purchase, for yourself and/or your family, other health coverage. Certifications may be requested within twenty-four (24) months of losing coverage.

You may also request certification be provided to you at any other time, even if you have not lost your coverage under this Contract. If you have any other questions regarding certification of creditable coverage, contact the Customer Service telephone number on the back of your Identification Card.]

ARTICLE 11. GENERAL PROVISIONS

A. **Entire Contract**. This Contract, the Schedule of Benefits, and any application, rider or amendment(s) make up the entire agreement between you and us as of the Effective Date and supersede all other agreements. All statements made by you shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce coverage under this Contract or be used in defense of a legal action unless it is contained in the application.

B. **No Assignment**. The benefits provided under this Contract are for your and your enrolled Dependents' personal benefit. You may not assign any of your rights to coverage. Any attempt by you to assign this Contract to any third party is void. Provided, however, that subject to our right to disapprove, you may assign your right to reimbursement for Covered Services to the Provider who provided such Covered Services.

C. **Notice**. Any notice that we give to you under this Contract will be mailed to your address as it appears on our records. Our notice to the Subscriber is deemed notice to all enrolled Dependents. Notice is deemed delivered three (3) calendar days after its deposit in the United State Mail with first class postage prepaid unless otherwise stated in this Contract. If you have to give us any notice, it should be mailed to:

Indiana University Health Plans, Inc.
950 North Meridian Street, Suite 200
Indianapolis, Indiana 46204

D. **Relationship Between Parties**. The relationships between us and Participating Providers are *solely* contractual relationships between a payor and independent contractors. Non-Participating Providers have no contractual relationship with us, nor are they our independent contractors. Providers are not our agents or employees. We and our employees are not employees or agents of Providers. The relationship between a Provider and any Covered Person is that of Provider and patient. The Provider is *solely* responsible for the services provided to any Covered Person.

E. **Disagreement with Recommended Treatment.** Each Covered Person enrolls in this Contract with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate Health Care Services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice. If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, the Provider and we, as applicable, may determine that neither this Contract nor the Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of this Contract for the condition under treatment or any complications thereof.

F. **Your Medical Records**. As a condition precedent to the approval of claims hereunder, each Covered Person authorizes and directs any Provider that furnishes benefits hereunder to make available to us information relating to all Health Care Services, copies thereof and other records as needed by us for purposes of administering this Contract. In every case we will hold such information and records as confidential in accordance with state and federal confidentiality requirements.

G. **Second Opinion Policy**. A second opinion may be required at our discretion prior to the scheduling of certain Covered Services. We will advise you if a proposed Covered Service is subject to the second opinion policy. If so, you must consult with a second Participating Provider prior to the scheduling of the service. You must (a) contact us to obtain a list of Participating Providers who are authorized to render a second opinion, and (b) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider. You must obtain the second opinion within thirty-one (31) days of the first opinion or as soon thereafter as is reasonably possible. Second opinions we have arranged as described above are provided at no cost to you. A second opinion may also be obtained at the request of a Covered Person, subject to separate benefit restrictions and/or Copayments or Coinsurance described in this Contract.

H. **Who May Change This Contract**. This Contract may not be modified, amended or changed, except in writing, and signed by one of our officers. No employee, agent or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage or the conditions of eligibility, enrollment or participation unless in writing and signed by one of our officers. We are not bound by any verbal statements. We will provide you with written notice of any material modification to this Contract not later than sixty (60) days prior to the date on which such material modification will become effective.

I. **Renewal Date**. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date for the term set forth in the Contract unless otherwise terminated by us as permitted by the Contract or by you upon thirty (30) days' prior written notice.

J. **Identification Cards**. Identification Cards are issued by us for identification only. Possession of any Identification Card confers no right to services or benefits under this Contract. To be entitled to such services or benefits the Covered Person's premiums must be paid in full at the time the Health Care Services are sought to be received. Coverage under this Contract may be terminated by us if the Covered Person allows another person to wrongfully use the Identification Cards.

K. **Right to Develop Guidelines and Administrative Rules**. We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Contract. An example of the use of the standards is to determine whether care was Medically Necessary. These standards will not be contrary to the descriptions in this Contract. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Contract.

L. **Non-Discrimination**. In compliance with state and federal law, we shall not discriminate on the basis of age; gender; color; race; disability; marital status; sexual preference; religious affiliation; or public assistance status. We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care. We shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew Coverage, (b) cancel coverage, (c) limit Benefits, or (d) charge a different premium. We shall not discriminate against victims of abuse in compliance with Indiana Code Sec. 27-8-24.3-1.

M. **Incontestability**. The validity of the Contract may not be contested after two (2) years, except for nonpayment of premiums or if the disputed statement is in a written instrument signed by the Subscriber. The ineligibility of the Subscriber or a Dependent under the Contract may be disputed at any time.

N. **Limitation of Action**. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Contract and within three (3) years from the date the Health Care Services were received.

O. **Examination of Covered Persons**. We may reasonably require that you be examined if a question or dispute about the provision of or payment for Covered Services arises. The exam will be performed by a Participating Provider acceptable to us. We will pay for the exam.

P. **Right of Recovery.** If we pay for Health Care Services that, according to the terms of the Contract, should not have been paid, we reserve the right to recover such amounts from whom they have been paid (including the Covered Person or Provider) or any other appropriate party.

Q. **Contract is not a Medicare supplement policy**. Any Covered Services that are covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled. The benefits under this Contract for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be Primary. Where Medicare is Primary, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

R. **Contract is Not Worker's Compensation Insurance**. The coverage provided under this Contract does not replace, supplement or provide a substitute for benefits to which a Covered Person is entitled under worker's compensation, occupational disease, and similar laws. The Contract does not cover Health Care Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's

compensation, occupational disease and similar laws, even when the circumstances below are present.

(1) If the Covered Person's employer is not properly insured or self-insured under such laws.

(2) When a Covered Person refuses to use his or her employer's designated Provider.

(3) When a Covered Person has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

A Covered Person must contact his employer or its worker's compensation or occupational disease insurer for the provision or payment of such Health Care Services.

S. General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within our control we will pay benefits for Covered Services as provided in this Contract to the extent that facilities and personnel are then available, and we shall have no liability or obligation for delay or failure to provide Covered Services due to lack of available facilities or personnel.

T. Typographical or Administrative Error. Typographical or administrative errors shall not deprive a Covered Person of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

U. Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on the Effective Date shall apply. Any Contract provision which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

V. Governing Law. This Contract will be subject to the laws of the state of Indiana.

W. Severability. In the event that any provision in the Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

[Schedule of Benefits]

Actuarial Memorandum

Indiana University Health Plans, Inc.

Individual Health Rate Filing

Effective January 1, 2015 through December 31, 2015

Form: 13164.1-Indiv-Policy-Adult (01/2015)

13164.1-Indiv-Policy-Child (01/2015)

Submitted: May 28, 2014

TABLE OF CONTENTS

1) General Information 3
2) Proposed Rate Increase(s) 4
3) Experience Period Premium and Claims 4
4) Benefit Categories 5
5) Projection Factors 5
6) Credibility Manual Rate Development 5
7) Credibility of Experience 7
8) Paid to Allowed Ratio 7
9) Risk Adjustment and Reinsurance 8
10) Non-Benefit Expenses and Profit & Risk 8
11) Projected Loss Ratio 9
12) Single Risk Pool 10
13) Index Rate 10
14) Market Adjusted Index Rate 10
15) Plan Adjusted Index Rates 11
16) Calibration 12
17) Consumer Adjusted Premium Rate Development 13
18) AV Metal Values 13
19) AV Pricing Values 14
20) Membership Projections 14
21) Terminated Products 14
22) Plan Type 14
23) Warning Alerts 14
24) Company Financial Position 14
25) Reliance 15
26) Actuarial Certification 15

1) General Information

Overview

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template (URRT), which supports compliance with the market rating rules and reasonableness of applicable rate increases.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with State of Indiana statutes and provisions of the Affordable Care Act (ACA). This memorandum documents the development of the Individual rates for Indiana University Health Plans, Inc. (IUHP). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This information may not be appropriate for other purposes.

This information is intended for use by the State of Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of IUHP's Individual rate filing. However, we recognize that this certification may become a public document. PwC makes no representations or warranties regarding the contents of this memorandum to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for IUHP by PwC that would result in the creation of any duty or liability under any theory of law by PwC or its employees to third parties.

These results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

Company Identifying Information

- Company Legal Name: Indiana University Health Plans, Inc.
- State: The State of Indiana has regulatory authority over these policies
- HIOS Issuer ID: 33380
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: Eric Neuville, Vice President Product Development and Innovation
- Primary Contact Telephone Number: (317) 963-1835
- Primary Contact Email Address: eneuville@iuhealth.org

Certifying Actuary Contact Information

- Primary Contact Name: Robert Macagnano, PwC
- Primary Contact Telephone Number: (973) 236-4082
- Primary Contact Email Address: robert.macagnano@us.pwc.com

Benefit Summary

IUHP will be offering three Bronze, three Silver, and one Gold HMO products. A summary of the major provisions of each plan are provided in Appendix A.

Premium Guarantee Provision

Premiums are guaranteed not to change through December 31, 2015.

Renewability

The policy is renewable by paying the applicable renewal premiums unless the policyholder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability

The rates will apply to new business. Subsequent renewal business will be subject to rates filed for our 2016 rate development.

Premium Modalization

Premiums will be collected only on a monthly basis.

Trend Assumption

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2) Proposed Rate Increase(s)

This is a new filing therefore no rate increase assumption is included in this filing. Subsequent rate increases beginning with effective dates of January 1, 2016 will be filed in the future.

3) Experience Period Premium and Claims

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

4) Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.

Capitation: Includes capitated services for pediatric vision benefits.

Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

5) Projection Factors

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6) Credibility Manual Rate Development

The PwC Rating Model was used as the basis to develop the manual rates. Our model was developed using two primary sources:

- Commercial Truven Health MarketScan® Research Databases for U.S. members and providers. The database contains full enrollment and claims information with standard medical coding which allows for cost and utilization information by service category (inpatient, outpatient hospital, hospice, home health, professional, prescription drugs, etc.). The database consists of the experience from 53 million Commercial eligible participants. The data can be extracted down to the member's state and MSA level. For the Indiana Commercial market, there were approximately 1.5 million exposed life years' worth of data crossing all ages, genders and employment statuses (active, COBRA, disabled and retired). Nationwide, the databases have over 100 unique data contributors so it is not skewed to any one payer.
- OptumInsight (Optum) Comprehensive Pricing Model® provides benchmark data and pricing capabilities for Commercial health plans. It factors in health plan features such as deductibles, copays, out-of-pocket maximums, covered services, etc. The model uses normative data and benefit details to arrive at an allowed cost per member per month. The

normative benchmarking utilization metrics within the model are developed from Optum's database of Commercial (under 65) health plan experience of approximately 20 million life years. The model experience was adjusted to reflect the Indiana marketplace.

Since both the Truven and Optum data sources represent fully-completed calendar year 2012 claims, allowed costs were trended to the midpoint of calendar year 2015 using an annual trend rate of 7.4%.

The allowed costs component of the manual rates was increased by 2% to account for expected changes in covered benefits due to the Essential Health Benefits (EHB) requirements. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- State mandated benefits included in the EHB that previously only applied to group coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

In our May 9, 2014 filing, we noted that the Indiana Department of Insurance (IDOI) was expected to provide additional information pertaining to the Medicaid Spend-Down population. IUHP also reserved the right to revise their initial filing to reflect any additional data. Subsequent to IUHP's May 9, 2014 filing, the IDOI released additional SFY 2013 information pertaining to the Medicaid Spend-Down population which included the following:

- Summary of unique individuals, Medicaid allowed, Medicaid paid, and billed charges by age band, gender, and FPL % category
- Summary of the Medicaid allowed, Medicaid paid, and Billed charges for each unique individual
- Summary of unique individuals, Medicaid allowed, Medicaid paid, and billed charges by county

The manual rates were increased by 5.2% to reflect the entrance of approximately 7,000 Medicaid Spend-Down beneficiaries into the Indiana Health Insurance Exchange. This adjustment was based on the assumption that IUHP's penetration of the Medicaid Spend-Down population would be similar to their assumed penetration of the general population for the counties included in IUHP's proposed service area.

There will also be new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services. Pent up demand has been shown to increase costs in the first year of enrollment for those

previously uninsured. Based on analysis of programs serving a similar population, it appears that the claims are higher in the first six to 12 months that an individual is newly insured. After this initial period, the claims experience tends to revert to the average level for the market. The total effect is uncertain and may be offset by some new enrollees having reduced utilization as they may not fully understand new or increased coverage. Therefore, we have included an adjustment within our manual rate development for pent up demand of 5.0%.

The following adjustments were made to calibrate the pricing model to the expected population:

- Rating region
- Expected demographics
- Expected morbidity
- Contractual Agreements with healthcare providers
- Expected utilization management savings
- Benefit plan designs

Some benefits will be reimbursed under a capitation arrangement. The provider reimbursement adjustment to the pricing model was developed to account for the cost of capitated services.

The manual rates were also adjusted upward by a factor of 1.005 to account for the likelihood that some enrollees may not pay their premiums due during the first month of the 90-day grace period. This was calculated assuming a 15% rate of non-payment on one-twelfth of the annual premium due for 80% of the Individual population (those eligible for Advance Payments of a Premium Tax Credit). The amount of premium at risk is only on the portion that IUHP does not receive via direct subsidy, estimated to be 50% (0.15 x 1/12 x 0.80 x 0.50 = 0.005). The 15% represents our assumption regarding the small portion of enrollees that we believe will knowingly take advantage of the grace period provision. The 80% represents the portion of enrollees in the 2015 Individual marketplace that we assume will be eligible for premium subsidies based on income level. On May 1, 2014 the Department of Health and Human Services reported that as of April 19, 2014, 89% of those enrolled in the Indiana exchange were eligible for federal assistance. Our assumption is that this percentage will decrease during 2015.

7) Credibility of Experience

IUHP has not previously operated in the individual market. As a result the “Experience Period” section of Worksheet 1 of the URRT has not been populated. Similarly, the projection factors (cells J24:M29 on Worksheet 1) have also been left blank. The service category PMPMs shown in the “Credibility Manual” section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

8) Paid to Allowed Ratio

The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT calculates the PMPM costs on both an allowed and paid basis. The “Paid to Allowed Average Factor in Projection Period” shown on Worksheet 1, Section III of the URRT is developed by membership-weighted EHB paid claims divided by membership-weighted EHB allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

9) Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, IUHP is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value. Therefore, no risk adjustment PMPM payment is assumed for 2015.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only)

The Federal transitional reinsurance program is a temporary risk mitigation program expected to reduce costs for insurance issuers. The 2015 reinsurance program has an attachment point of $70,000 and a maximum coverage limit of $250,000 per member. The Department of Health and Human Services will reimburse insurance issuers 50% of paid costs between the attachment point and maximum coverage limit.

Allowed claims were reduced by 7.0% to account for the anticipated 2015 reimbursements from this temporary program. This estimate was developed using projected paid claims, a claims probability distribution calibrated to the expected average claim levels for the 2015 Individual market, and the federal program guidelines summarized above. The expected reinsurance reimbursements are $46.95 PMPM. Applying the 2015 transitional reinsurance charge of $3.67 PMPM yields a net reinsurance cost of $43.28 PMPM.

Projected Net Cost of Private Reinsurance

The projected net cost of private reinsurance for 2015 is $0.00 PMPM since IUHP does not intend to purchase private reinsurance.

10) Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

IUHP developed their expected administrative expenses based on: a) current administrative expenses for their Medicare line of business adjusting for any expected differences for their Commercial products, and b) a review of 2014 Rate Filings for Individual Exchange products. A summary of IUHP's assumptions is as follows:

- Administrative expenses (excluding Sales and Marketing expenses): 10.50% of premium
- Sales and Marketing expenses (including commissions): $6.18 PMPM

These administrative expenses are allocated proportionally by plan.

Quality Improvement Expenses

At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. Therefore, no explicit Quality Improvement expenses were assumed.

Profit & Risk Margin

The proposed rates reflect a profit & risk margin of 3.0% of premium. This load was applied to all products and plans.

Taxes and Fees

A summary of the assumed taxes and fees are summarized below:

PMPM Basis

- Transitional reinsurance charge: $3.67 PMPM ($44.00 per member per year)
- Risk adjustment user fee: $0.08 PMPM
- PCORI fee: $0.17 PMPM ($2.00 per member per year)

Percentage of Premium Basis

- Health insurance exchange fee: 3.15% of premium reflecting IUHP's assumption that 90% of their expected 2015 business will be sold through the exchange
- ACA issuer fee: IUHP will not be subject to this fee for 2015
- Premium tax: 1.30% of premium

11) Projected Loss Ratio

The overall projected medical loss ratio for 2015 is 85.2%. This calculation excludes regulatory fees and taxes. At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. As a result, we have not included an adjustment in the MLR calculation for these expenses. It is IUHP's intent to identify their Quality Improvement expenses for purposes of submitting their MLR-related filings and calculating related rebates, if any. The following table shows the calculation.

a)	Incurred Claims Net of Cost Sharing	$455.14
b)	Transitional Reinsurance Reimbursement	($46.95)
c)	Reinsurance Charge	$3.67
d)	Quality Improvement Expenses	$0.00
e)	Worksheet 1 Projected Incurred Claims (a+b+c+d)	$411.86
f)	Administrative Expenses	$59.70
g)	Profit & Risk Margin	$15.29
h)	Regulatory Taxes and Fees (excluding reinsurance charge)	$22.93
i)	Gross Premium (e+f+g+h)	$509.79
j)	Medical Loss Ratio (e/(i-c-h))	85.2%

12) Single Risk Pool

IUHP has not previously operated in the Individual market and thus does not have any claims experience to develop its own Single Risk Pool. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

13) Index Rate

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the Index Rate for the Experience Period has been left blank.

The Index Rate of $670.70 for the 2015 Projection Period represents the overall projected allowed costs PMPM for providing Essential Health Benefits for the Single Risk Pool. Since this is a new product, the index rate was developed based on a manual rate as described above in the Credibility Manual Rate Development section. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

14) Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic

characteristics of the Single Risk Pool. In other words, the Market Adjusted Index Rate is not calibrated.

The development of the Federal reinsurance program and risk adjustments was described above in the Risk Adjustment and Reinsurance section. The development of the Exchange user fee adjustment was described above in the Non-Benefit Expenses and Profit & Risk section.

Index Rate	$670.70
Reinsurance Reimbursements (7.0% of Allowed Claims – Index Rate)	($46.95)
Reinsurance Premiums	$ 3.67
Risk Adjustment	$ 0.00
Exchange user fee (3.15% of average premium for Single Risk Pool)	$ 16.06
Market Adjusted Index Rate	$643.47

15) Plan Adjusted Index Rates

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the Part I Unified Rate Review Template in 2015. These Plan Adjusted Index Rates have been adjusted to remove the portion of the allowed cost that is expected to be recouped through the tobacco surcharge. The average tobacco surcharge for the Single Risk Pool is approximately 1.4%.

The Plan Adjusted Index Rates reflect the average demographic characteristics of the Single Risk Pool. In other words, the Plan Adjusted Index Rates are not calibrated.

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

- Actuarial value and cost sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)
- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

Only the actuarial value and cost sharing & distribution and administrative costs adjustments were applicable to IUHP.

Actuarial Value and Cost Sharing Adjustment

This adjustment includes three components:

- Removal of tobacco surcharge - the average tobacco surcharge factor was applied to the average allowed costs for the Single Risk Pool
- Benefit richness utilization adjustments - The reference plan underlying our pricing was a Silver plan. Benefit richness utilization adjustments were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge). These

adjustments were based on the values published in the Federal Register payment notice, normalized to the Silver plan level. The adjustments for each metallic tier are as follows:

- Bronze = 1.00 / 1.03 = 0.9709
- Silver = 1.00 / 1.00 = 1.0000
- Gold = 1.08 / 1.03 = 1.0485

- Cost Sharing - The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT was used to calculate the cost sharing percentage for each plan. These cost sharing percentages were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge and applying the benefit richness utilization adjustments). The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

Adjustment for Distribution and Administrative Costs

Fixed and variable costs as described in the Non-Benefit Expenses and Profit & Risk section were included in this adjustment as follows:

- Fixed costs: Risk adjustment user fee, PCORI fee, and sales & marketing expenses
- Variable costs (% of premium): Administrative expenses, profit & risk margin, and premium taxes. The percentages applied did not vary by plan.

Appendix D shows the development of the Plan Adjusted Index Rates.

16) Calibration

The Plan Adjusted Index Rates (which are based on the Single Risk Pool) were calibrated to apply the allowable rating factors in order to calculate Consumer Adjusted Premium Rates. The calibration by age and geography is described below.

Age Curve Calibration

The methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology and conforms with the rating rules specified in 45 CFR 147.102.

The expected membership distribution by age band was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. A uniform distribution within each age band was also assumed. A weighted average age factor of 1.685 for the Single Risk Pool was also determined by applying the membership distribution to the Federal age curve. This represents a rounded weighted average age of 49. Appendix C shows the development of the weighted average age factor.

The Plan Index Rates were calibrated by dividing by 1.706 which represents the standard age factor of the rounded weighted average age of 49. This calibration factor does not vary by plan.

Geographic Factor Calibration

A geographic factor calibration was not required since the weighted average of the geographic factors equals 1.0. The Geographic (rating area) factors were developed based upon the network characteristics for unit cost and utilization management in each of the established rating areas. Based upon the expected distribution of enrolment by area, the area factors reflect the Single Risk Pool results consistent with the URRT.

Appendix D shows how the calibration adjustments were applied to the Plan Adjusted Index Rates.

17) Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography if necessary, and applying the rating factors specified by 45 CFR Part 147, §147.102. The following adjustments are allowable under this rule:

- Whether the plan coverage covers an individual or family (issuers must cover any eligible individual and/or eligible family that requests coverage per the guaranteed issue requirement of the ACA); this is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor
- Rating area
- Age – reflecting the applicable age curve
- Tobacco status

The rating factors (shown in Appendix C) are applied at an individual level and added together to calculate the family rate, with the exception that no more than 3 covered children under the age of 21 are charged a rate. Adjustment for family size is in accordance with Federal rules. The examples in Appendix E show how the rating factors are applied to the calibrated Plan Adjusted Index Rate.

18) AV Metal Values

The Federal AV calculator was used without any modifications to generate the Metal Values included in Worksheet 2 of the URRT. Please refer to Appendix F for screen shots showing the AV calculations for each plan.

19) AV Pricing Values

The Silver Value plan was selected as the fixed reference plan and serves as the basis for the AV Pricing Values. Please refer to Appendix C for the AV Pricing Values for each plan which are also included in Worksheet 2, Section I of the URRT. The AV Pricing Value for each plan reflects the relative impact of the plan's cost-sharing amounts, expected impact on enrollee utilization due to benefit richness (excluding impact of morbidity), expected additional cost of non-EHB, and administrative expenses (excluding health insurance exchange user fees).

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the PwC Rating Model as described above in the Credibility Manual Rate Development section was used to develop the benefit relativities for the AV Pricing Values.

20) Membership Projections

Membership projections were based on market penetration assumptions provided by IUHP. These assumptions reflected the uninsured and individual market populations by county, income level, and other characteristics such as the presence of IUHP facilities and delivery system within a given county.

The expected membership distribution by age band and metallic tier was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. For the Silver plans, the portion of the projected enrollment that will be eligible for CSR subsidies at each subsidy level was based on the income level detail in the market penetration analysis provided by IUHP.

Summaries of the projected membership by age, metallic tier, and CSR subsidy level are shown in Appendix B.

21) Terminated Products

Not applicable. IUHP does not currently have Individual plans in the State of Indiana.

22) Plan Type

All plans listed types in Worksheet 2, Section I of the URRT correctly describe IUHP's plans as "HMO".

23) Warning Alerts

There were no warnings generated on Worksheet 2 of in the URRT.

24) Company Financial Position

Please see Appendix G for information regarding the capital and surplus position of IUHP.

25) Reliance

In the preparation of this filing, I have relied upon data provided by Eric Neuville (Vice President Product Development and Innovation), Connie Brown (CFO and COO), and IUHP management. I did not audit this data but did review it for reasonableness. This information includes but is not limited to the following items:

- Administrative expense projections (including commissions)
- Provider reimbursement levels (including capitation arrangements)
- Projected enrollment
- Projected pharmacy discounts, unit costs and rebates
- Financial statement information

26) Actuarial Certification

I, Robert Macagnano, FSA, MAAA, am affiliated with PricewaterhouseCoopers LLP (PwC). I am a Member of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinion contained herein. This filing is prepared on behalf of Indiana University Health Plans, Inc. (the "Company").

I certify that this filing has been prepared in accordance with the following Actuarial Standards of Practice (ASOP) including:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications

I certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

I certify that the Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

On/Off Exchange Attestation

I certify that a single set of premium rates was submitted with this filing which is applicable for all plans offered both on and off the Exchange, and that this assures the same premium rate will be charged without regard to whether the plan is offered through the Exchange or whether the plan is offered directly from the Company or through an agent.

QHP Off Exchange Premium Tax Credit (PTC) Attestation

To notify consumers that coverage purchased outside of the Exchange is not eligible for premium tax credit assistance, the Company will include the following language in their marketing materials:

"DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace."

This disclaimer is located on page 1 of the Company's policy form.

The Part I Unified Rate Review Template does not demonstrate the process used by the Company to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Respectfully submitted,



Robert Macagnano, FSA, MAAA
Director
(973) 236-4082
Robert.Macagnano@us.pwc.com

Appendix A
Indiana University Health Plans, Inc.
Plan Design Summaries

Plan Name	Deductible	OOP Max	Coinsurance	PCP Visit	Specialist Visit	ER Visit	Inpatient Stay	Rx - Retail	Rx - Mail Order
IU Health Plans Gold Value	$750/$1,500	$6,000/$12,000	20% after deductible	$20 copay	$50 copay before deductible and 20% after deductible	$200 copay then deductible and 20% coinsurance	$500 copay then deductible and 20% coinsurance	$8/$20/20%/30%/30% (coinsurance applies after deductible)	$24/$60/20%/30%/30% (coinsurance applies after deductible)
IU Health Plans Silver HSA	$2,750/$5,500	$3,600/$7,200	10% after deductible	10% after deductible	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% after deductible	$15/$45/25%/35%/35% after deductible
IU Health Plans Silver Value	$2,500/$5,000	$6,350/$12,700	10% after deductible	$40 copay	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Silver Enhanced	$2,000/$4,000	$5,750/$11,500	20% after deductible	$30 copay	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Bronze HSA	$4,500/$9,000	$6,350/$12,700	20% after deductible	20% after deductible	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$10/$25/30%/40%/40% after deductible	$30/$75/30%/40%/40% after deductible
IU Health Plans Bronze Value	$6,000/$12,000	$6,350/$12,700	25% after deductible	$40 copay	25% after deductible	$350 copay then deductible and 25% coinsurance	$1,500 copay then deductible and 25% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)
IU Health Plans Bronze Enhanced	$5,000/$10,000	$6,350/$12,700	40% after deductible	$50 copay before deductible and then 40% after deductible	40% after deductible	$275 copay then deductible and 40% coinsurance	$750 copay then deductible and 40% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area

Member Distribution by Age	
Age Band	**Membership Distribution**
0-20	10.15%
21	1.09%
22	1.09%
23	1.09%
24	1.09%
25	1.09%
26	1.85%
27	1.85%
28	1.85%
29	1.85%
30	1.85%
31	1.85%
32	1.85%
33	1.85%
34	1.85%
35	1.68%
36	1.68%
37	1.68%
38	1.68%
39	1.68%
40	1.68%
41	1.68%
42	1.68%
43	1.68%
44	1.68%
45	2.12%
46	2.12%
47	2.12%
48	2.12%
49	2.12%
50	2.12%
51	2.12%
52	2.12%
53	2.12%
54	2.12%
55	2.98%
56	2.98%
57	2.98%
58	2.98%
59	2.98%
60	2.98%
61	2.98%
62	2.98%
63	2.98%
64	2.98%
65 and over	0.00%

Membership Distribution by Rating Area	
Rating Area	**Membership Distribution**
5	4.5%
7	30.9%
8	17.7%
10	9.0%
11	2.9%
13	29.9%
15	5.1%
Total	**100.0%**

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area
(continued)

		Silver					
Plan Name	**Gold**	**70**	**CSR 73**	**CSR 87**	**CSR 94**	**Bronze**	**Total**
IU Health Plans Gold Value	73						73
IU Health Plans Silver HSA		28	-	-	-		28
IU Health Plans Silver Value		168	152	284	69		673
IU Health Plans Silver Enhanced		84	76	142	35		337
IU Health Plans Bronze HSA						35	35
IU Health Plans Bronze Value						210	210
IU Health Plans Bronze Enhanced						105	105
Total	73	280	229	426	104	351	1,462

Appendix C
Indiana University Health Plans, Inc.
Rating Factors

Age-Based Tobacco Factors		
Age	**Smoker**	**Non-smoker**
0-20	1.000	1.000
21	1.050	1.000
22	1.050	1.000
23	1.050	1.000
24	1.050	1.000
25	1.050	1.000
26	1.050	1.000
27	1.050	1.000
28	1.050	1.000
29	1.050	1.000
30	1.050	1.000
31	1.070	1.000
32	1.090	1.000
33	1.110	1.000
34	1.130	1.000
35	1.150	1.000
36	1.170	1.000
37	1.190	1.000
38	1.210	1.000
39	1.230	1.000
40	1.250	1.000
41	1.270	1.000
42	1.290	1.000
43	1.310	1.000
44	1.330	1.000
45	1.350	1.000
46	1.370	1.000
47	1.390	1.000
48	1.410	1.000
49	1.430	1.000
50	1.450	1.000
51	1.470	1.000
52	1.490	1.000
53	1.490	1.000
54	1.473	1.000
55	1.410	1.000
56	1.348	1.000
57	1.290	1.000
58	1.234	1.000
59	1.208	1.000
60	1.158	1.000
61	1.118	1.000
62	1.094	1.000
63	1.065	1.000
64	1.048	1.000
65 and over	1.048	1.000

Federal Age Curve		
Age Band	**Membership Distribution**	**Age Factor**
0-20	10.15%	0.635
21	1.09%	1.000
22	1.09%	1.000
23	1.09%	1.000
24	1.09%	1.000
25	1.09%	1.004
26	1.85%	1.024
27	1.85%	1.048
28	1.85%	1.087
29	1.85%	1.119
30	1.85%	1.135
31	1.85%	1.159
32	1.85%	1.183
33	1.85%	1.198
34	1.85%	1.214
35	1.68%	1.222
36	1.68%	1.230
37	1.68%	1.238
38	1.68%	1.246
39	1.68%	1.262
40	1.68%	1.278
41	1.68%	1.302
42	1.68%	1.325
43	1.68%	1.357
44	1.68%	1.397
45	2.12%	1.444
46	2.12%	1.500
47	2.12%	1.563
48	2.12%	1.635
49	2.12%	1.706
50	2.12%	1.786
51	2.12%	1.865
52	2.12%	1.952
53	2.12%	2.040
54	2.12%	2.135
55	2.98%	2.230
56	2.98%	2.333
57	2.98%	2.437
58	2.98%	2.548
59	2.98%	2.603
60	2.98%	2.714
61	2.98%	2.810
62	2.98%	2.873
63	2.98%	2.952
64	2.98%	3.000
65 and over	0.00%	3.000
Weighted average age factor		1.685

Appendix C
Indiana University Health Plans, Inc.
Rating Factors
(continued)

Geographic Factors		
Rating Area	**Membership Distribution**	**Rating Area Factor**
5	4.5%	0.976
7	30.9%	0.976
8	17.7%	1.006
10	9.0%	1.060
11	2.9%	0.972
13	29.9%	1.010
15	5.1%	0.998
Total	**100.0%**	**1.000**

Plan Value Factors	
Plan Name	**Pricing Value**
IU Health Plans Gold Value	1.203
IU Health Plans Silver HSA	0.990
IU Health Plans Silver Value	1.000
IU Health Plans Silver Enhanced	1.009
IU Health Plans Bronze HSA	0.802
IU Health Plans Bronze Value	0.824
IU Health Plans Bronze Enhanced	0.834

Appendix D
Indiana University Health Plans, Inc.
Plan Adjusted Index Rate Development

Plan Name	Market adjusted index rate (a)	Actuarial value and cost sharing adjustment (b)	Adjustment for distribution and administrative costs (c)	Plan adjusted index rate (d) = (a) + (b) + (c)	Age calibration (e)	Geographic calibration (f)	Calibrated base rate (g) = (d) / [(e) x (f)]
IU Health Plans Gold Value	$ 643.47	$(120.70)	$98.43	$621.20	1.706	1.000	$364.13
IU Health Plans Silver HSA	$ 643.47	$(214.09)	$82.06	$511.44	1.706	1.000	$299.79
IU Health Plans Silver Value	$ 643.47	$(209.80)	$82.80	$516.48	1.706	1.000	$302.74
IU Health Plans Silver Enhanced	$ 643.47	$(205.97)	$83.47	$520.97	1.706	1.000	$305.38
IU Health Plans Bronze HSA	$ 643.47	$(296.83)	$67.60	$414.24	1.706	1.000	$242.81
IU Health Plans Bronze Value	$ 643.47	$(287.20)	$69.27	$425.54	1.706	1.000	$249.44
IU Health Plans Bronze Enhanced	$ 643.47	$(282.71)	$70.05	$430.81	1.706	1.000	$252.53

Appendix E
Indiana University Health Plans, Inc.
Rating Examples

Selected Plan:	IU Health Plans Silver Value
Rating Area:	Rating Area 11

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$302.74	0.972	2.230	1.410	$925.37
Spouse	40	Non-Smoker	$302.74	0.972	1.278	1.000	$376.12
Child 1	18	Non-Smoker	$302.74	0.972	0.635	1.000	$186.88
Child 2	15	Smoker	$302.74	0.972	0.635	1.000	$186.88
Child 3	13	Non-Smoker	$302.74	0.972	0.635	1.000	$186.88
Child 4	10	Non-Smoker	$302.74	0.972	0.635	1.000	$0.00
Total Premium							$1,862.13

Selected Plan:	IU Health Plans Gold Value
Rating Area:	Rating Area 7

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$364.13	0.976	2.230	1.410	$1,117.24
Spouse	40	Non-Smoker	$364.13	0.976	1.278	1.000	$454.10
Child 1	18	Non-Smoker	$364.13	0.976	0.635	1.000	$225.63
Child 2	15	Smoker	$364.13	0.976	0.635	1.000	$225.63
Child 3	13	Non-Smoker	$364.13	0.976	0.635	1.000	$225.63
Child 4	10	Non-Smoker	$364.13	0.976	0.635	1.000	$0.00
Total Premium							$2,248.24

Appendix F
Indiana University Health Plans, Inc.
Federal AV Calculator Results

IU Health Plans Gold Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☑		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.80	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.4%
Metal Tier:	Gold

IU Health Plans Silver HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.0%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.1%
Metal Tier:	Gold

IU Health Plans Silver HSA - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$400.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.1%
Metal Tier:	Platinum

IU Health Plans Silver Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.4%
Metal Tier:	Gold

IU Health Plans Silver Value - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

IU Health Plans Silver Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.7%
Metal Tier:	Gold

IU Health Plans Silver Enhanced - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$150.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$650.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

IU Health Plans Bronze HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.6%
Metal Tier:	Bronze

IU Health Plans Bronze Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	**Drug**	**Combined**	**Medical**	**Drug**	**Combined**
		$6,000.00			
		75.00%			
		$6,350.00			

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$350.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze

IU Health Plans Bronze Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,350.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$275.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☑		$50.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.8%
Metal Tier:	Bronze

Appendix G
Indiana University Health Plans, Inc.
Capital, Surplus, and RBC Information

Annual Statement for the year 2013 of the Indiana University Health Plans, Inc.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)				
2. Stocks (Schedule D):				
2.1 Preferred stocks				
2.2 Common stocks				
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens				
3.2 Other than first liens				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ encumbrances)				
4.2 Properties held for the production of income (less $ encumbrances)				
4.3 Properties held for sale (less $ encumbrances)				
5. Cash ($ 6,645,144, Schedule E - Part 1), cash equivalents ($, Schedule E - Part 2), and short-term investments ($, Schedule DA)	6,645,144		6,645,144	8,006,798
6. Contract loans (including $ premium notes)				
7. Derivatives (Schedule DB)				
8. Other invested assets (Schedule BA)				
9. Receivables for securities				
10. Securities lending reinvested collateral assets (Schedule DL)				
11. Aggregate write-ins for invested assets				
12. Subtotals, cash and invested assets (Lines 1 to 11)	6,645,144		6,645,144	8,006,798
13. Title plants less $ charged off (for Title insurers only)				
14. Investment income due and accrued	1,068		1,068	2,137
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	231,209	66,791	164,418	201,607
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ earned but unbilled premiums)				
15.3 Accrued retrospective premiums				
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers				
16.2 Funds held by or deposited with reinsured companies				
16.3 Other amounts receivable under reinsurance contracts				
17. Amounts receivable relating to uninsured plans				
18.1 Current federal and foreign income tax recoverable and interest thereon				
18.2 Net deferred tax asset				
19. Guaranty funds receivable or on deposit				
20. Electronic data processing equipment and software				
21. Furniture and equipment, including health care delivery assets ($)				
22. Net adjustment in assets and liabilities due to foreign exchange rates				
23. Receivables from parent, subsidiaries and affiliates	332,038		332,038	714,499
24. Health care ($ 449,493) and other amounts receivable	1,838,476	915,716	922,760	616,348
25. Aggregate write-ins for other than invested assets	1,110,648	156,922	953,726	510,111
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	10,158,583	1,139,429	9,019,154	10,051,500
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28. Total (Lines 26 and 27)	10,158,583	1,139,429	9,019,154	10,051,500

DETAILS OF WRITE-IN LINES				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	NONE			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501. Estimated Medicare Settlement Receivable	953,726		953,726	510,111
2502. Prepaid General and Administrative Expenses	156,922	156,922		
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page				
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	1,110,648	156,922	953,726	510,111

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ 0 reinsurance ceded)				
2.	Accrued medical incentive pool and bonus amounts				
3.	Unpaid claims adjustment expenses				
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Services Act	29,399		29,399	105,075
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	294,066		294,066	229,823
9.	General expenses due or accrued	818,192		818,192	1,431,649
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))				
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others				
13.	Remittances and items not allocated				
14.	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)				
15.	Amounts due to parent, subsidiaries and affiliates				12,550
16.	Derivatives				
17.	Payable for securities				
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified $ (0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans				
23.	Aggregate write-ins for other liabilities (including $ 0 current)	595,407		595,407	871,800
24.	Total liabilities (Lines 1 to 23)	1,737,064		1,737,064	2,650,897
25.	Aggregate write-ins for special surplus funds	XXX	XXX		
26.	Common capital stock	XXX	XXX	1,000	1,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	27,499,000	27,999,000
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	(20,217,910)	(20,599,397)
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX		
	32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	7,282,090	7,400,603
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	9,019,154	10,051,500

	DETAILS OF WRITE-IN LINES				
2301.	Estimated Medicare Settlement Liability	338,139		338,139	667,855
2302.	Other Amounts Payable	257,268		257,268	203,945
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	595,407		595,407	871,800
2501.		XXX	XXX		
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

NONE

NONE

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL - XR025

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		7,282,090	
(2)	Company Action Level=200% of Authorized Control Level	CAL	4,146,860	
(3)	Regulatory Action Level=150% of Authorized Control Level	RAL	3,110,145	
(4)	Authorized Control Level=100% of Authorized Control Level	ACL	2,073,430	
(5)	Mandatory Control Level=70% of Authorized Control Level	MCL	1,451,401	
(6)	Level of Action, if Any		NONE	

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	7,282,090
Authorized Control Level Risk-Based Capital on Line 15 of the Five Year Historical Data Page	2,073,430

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	98,250,957	
(8)	Underwriting Deductions	Page 4, Line 23	97,709,883	
(9)	Combined Ratio	Line (8)/Line(7)	99.400	
(10)	RBC Ratio	Line(1)/Line(4)	351.200	
(11)	Trend Test Result	If Line(10) is between 200% and 300% and Line (9) > 105%, then "Yes", otherwise "No"		No
(12)	Level of Action, if any, including Trend Test		NONE	

Actuarial Memorandum

Indiana University Health Plans, Inc.

Individual Health Rate Filing

Effective January 1, 2015 through December 31, 2015

Form: 13164.1-Indiv-Policy-Adult (01/2015)

13164.1-Indiv-Policy-Child (01/2015)

Submitted: May 9, 2014

TABLE OF CONTENTS

1) General Information 3
2) Proposed Rate Increase(s) 4
3) Experience Period Premium and Claims 4
4) Benefit Categories 5
5) Projection Factors 5
6) Credibility Manual Rate Development 5
7) Credibility of Experience 7
8) Paid to Allowed Ratio 7
9) Risk Adjustment and Reinsurance 8
10) Non-Benefit Expenses and Profit & Risk 8
11) Projected Loss Ratio 9
12) Single Risk Pool 10
13) Index Rate 10
14) Market Adjusted Index Rate 10
15) Plan Adjusted Index Rates 11
16) Calibration 12
17) Consumer Adjusted Premium Rate Development 12
18) AV Metal Values 13
19) AV Pricing Values 13
20) Membership Projections 13
21) Terminated Products 14
22) Plan Type 14
23) Warning Alerts 14
24) Company Financial Position 14
25) Reliance 14
26) Actuarial Certification 15

1) General Information

Overview

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template (URRT), which supports compliance with the market rating rules and reasonableness of applicable rate increases.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with State of Indiana statutes and provisions of the Affordable Care Act (ACA). This memorandum documents the development of the Individual rates for Indiana University Health Plans, Inc. (IUHP). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This information may not be appropriate for other purposes.

This information is intended for use by the State of Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of IUHP's Individual rate filing. However, we recognize that this certification may become a public document. PwC makes no representations or warranties regarding the contents of this memorandum to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for IUHP by PwC that would result in the creation of any duty or liability under any theory of law by PwC or its employees to third parties.

These results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

Company Identifying Information

- Company Legal Name: Indiana University Health Plans, Inc.
- State: The State of Indiana has regulatory authority over these policies
- HIOS Issuer ID: 33380
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: Eric Neuville, Vice President Product Development and Innovation
- Primary Contact Telephone Number: (317) 963-1835
- Primary Contact Email Address: eneuville@iuhealth.org

Certifying Actuary Contact Information

- Primary Contact Name: Robert Macagnano, PwC
- Primary Contact Telephone Number: (973) 236-4082
- Primary Contact Email Address: robert.macagnano@us.pwc.com

Benefit Summary

IUHP will be offering three Bronze, three Silver, and one Gold HMO products. A summary of the major provisions of each plan are provided in Appendix A.

Premium Guarantee Provision

Premiums are guaranteed not to change through December 31, 2015.

Renewability

The policy is renewable by paying the applicable renewal premiums unless the policyholder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability

The rates will apply to new business. Subsequent renewal business will be subject to rates filed for our 2016 rate development.

Premium Modalization

Premiums will be collected only on a monthly basis.

Trend Assumption

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2) Proposed Rate Increase(s)

This is a new filing therefore no rate increase assumption is included in this filing. Subsequent rate increases beginning with effective dates of January 1, 2016 will be filed in the future.

3) Experience Period Premium and Claims

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

4) Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.

Capitation: Includes capitated services for pediatric vision benefits.

Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

5) Projection Factors

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6) Credibility Manual Rate Development

The PwC Rating Model was used as the basis to develop the manual rates. Our model was developed using two primary sources:

- Commercial Truven Health MarketScan® Research Databases for U.S. members and providers. The database contains full enrollment and claims information with standard medical coding which allows for cost and utilization information by service category (inpatient, outpatient hospital, hospice, home health, professional, prescription drugs, etc.). The database consists of the experience from 53 million Commercial eligible participants. The data can be extracted down to the member's state and MSA level. For the Indiana Commercial market, there were approximately 1.5 million exposed life years' worth of data crossing all ages, genders and employment statuses (active, COBRA, disabled and retired). Nationwide, the databases have over 100 unique data contributors so it is not skewed to any one payer.
- OptumInsight (Optum) Comprehensive Pricing Model® provides benchmark data and pricing capabilities for Commercial health plans. It factors in health plan features such as

deductibles, copays, out-of-pocket maximums, covered services, etc. The model uses normative data and benefit details to arrive at an allowed cost per member per month. The normative benchmarking utilization metrics within the model are developed from Optum's database of Commercial (under 65) health plan experience of approximately 20 million life years. The model experience was adjusted to reflect the Indiana marketplace.

Since both the Truven and Optum data sources represent fully-completed calendar year 2012 claims, allowed costs were trended to the midpoint of calendar year 2015 using an annual trend rate of 7.4%.

The allowed costs component of the manual rates was increased by 2% to account for expected changes in covered benefits due to the Essential Health Benefits (EHB) requirements. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- State mandated benefits included in the EHB that previously only applied to group coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

The manual rates were increased by 15% to reflect the entrance of approximately 7,000 Medicaid Spend-Down beneficiaries into the Indiana Health Insurance Exchange. This adjustment was based on the assumption that IUHP's penetration of the Medicaid Spend-Down population would be similar to their assumed penetration of the general population. Expenditure information for the Medicaid Spend-Down population was provided by the Indiana Family and Social Services Administration and contained in the April 21, 2014 study "Spend Down Exchange Impact: Transition to the Indiana Health Insurance Exchange" performed by Milliman, Inc. In addition, preliminary estimates provided by the Indiana Department of Insurance (IDOI) during their May 2, 2014 Weekly ACA Rate & Form Filing Call Session indicated that the inclusion of this population would increase premiums by 5% - 15%. We have been informed by the IDOI that additional information pertaining to this population will be made available. We reserve the right to revise our filing to reflect this data subsequent to this filing.

There will also be new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services. Pent up demand has been shown to increase costs in the first year of enrollment for those previously uninsured. Based on analysis of programs serving a similar population, it appears that the claims are higher in the first six to 12 months that an individual is newly insured. After this initial period, the claims experience tends to revert to the average level for the market. The total effect is uncertain and may be offset by some new enrollees having reduced utilization as they may not fully

understand new or increased coverage. Therefore, we have included an adjustment within our manual rate development for pent up demand of 5.0%.

The following adjustments were made to calibrate the pricing model to the expected population:

- Rating region
- Expected demographics
- Expected morbidity
- Contractual Agreements with healthcare providers
- Expected utilization management savings
- Benefit plan designs

Some benefits will be reimbursed under a capitation arrangement. The provider reimbursement adjustment to the pricing model was developed to account for the cost of capitated services.

The manual rates were also adjusted upward by a factor of 1.005 to account for the likelihood that some enrollees may not pay their premiums due during the first month of the 90-day grace period. This was calculated assuming a 15% rate of non-payment on one-twelfth of the annual premium due for 80% of the Individual population (those eligible for Advance Payments of a Premium Tax Credit). The amount of premium at risk is only on the portion that IUHP does not receive via direct subsidy, estimated to be 50% (0.15 x 1/12 x 0.80 x 0.50 = 0.005). The 15% represents our assumption regarding the small portion of enrollees that we believe will knowingly take advantage of the grace period provision. The 80% represents the portion of enrollees in the 2015 Individual marketplace that we assume will be eligible for premium subsidies based on income level. On May 1, 2014 the Department of Health and Human Services reported that as of April 19, 2014, 89% of those enrolled in the Indiana exchange were eligible for federal assistance. Our assumption is that this percentage will decrease during 2015.

7) Credibility of Experience

IUHP has not previously operated in the individual market. As a result the “Experience Period” section of Worksheet 1 of the URRT has not been populated. Similarly, the projection factors (cells J24:M29 on Worksheet 1) have also been left blank. The service category PMPMs shown in the “Credibility Manual” section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

8) Paid to Allowed Ratio

The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT calculates the PMPM costs on both an allowed and paid basis. The “Paid to Allowed Average Factor in Projection Period” shown on Worksheet 1, Section III of the URRT is developed by membership-weighted EHB paid claims divided by membership-weighted EHB allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

9) Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, IUHP is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value. Therefore, no risk adjustment PMPM payment is assumed for 2015.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only)

The Federal transitional reinsurance program is a temporary risk mitigation program expected to reduce costs for insurance issuers. The 2015 reinsurance program has an attachment point of $70,000 and a maximum coverage limit of $250,000 per member. The Department of Health and Human Services will reimburse insurance issuers 50% of paid costs between the attachment point and maximum coverage limit.

Allowed claims were reduced by 7.0% to account for the anticipated 2015 reimbursements from this temporary program. This estimate was developed using projected paid claims, a claims probability distribution calibrated to the expected average claim levels for the 2015 Individual market, and the federal program guidelines summarized above. The expected reinsurance reimbursements of $51.43 PMPM are allocated proportionally by plan based on allowed claims. Applying the 2015 transitional reinsurance charge of $3.67 PMPM yields a net reinsurance cost of $47.76 PMPM.

Projected Net Cost of Private Reinsurance

The projected net cost of private reinsurance for 2015 is $0.00 PMPM since IUHP does not intend to purchase private reinsurance.

10) Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

IUHP developed their expected administrative expenses based on: a) current administrative expenses for their Medicare line of business adjusting for any expected differences for their Commercial products, and b) a review of 2014 Rate Filings for Individual Exchange products. A summary of IUHP's assumptions is as follows:

- Administrative expenses (excluding Sales and Marketing expenses): 10.50% of premium
- Sales and Marketing expenses (including commissions): 3.70% of premium

These administrative expenses are allocated proportionally by plan.

Quality Improvement Expenses

At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. Therefore, no explicit Quality Improvement expenses were assumed.

Profit & Risk Margin

The proposed rates reflect a profit & risk margin of 3.0% of premium. This load was applied to all products and plans.

Taxes and Fees

A summary of the assumed taxes and fees are summarized below:

PMPM Basis

- Transitional reinsurance charge: $3.67 PMPM ($44.00 per member per year)
- Risk adjustment user fee: $0.08 PMPM
- PCORI fee: $0.17 PMPM ($2.00 per member per year)

Percentage of Premium Basis

- Health insurance exchange fee: 3.15% of premium reflecting IUHP's assumption that 90% of their expected 2015 business will be sold through the exchange
- ACA issuer fee: IUHP will not be subject to this fee for 2015
- Premium tax: 1.30% of premium

11) Projected Loss Ratio

The overall projected medical loss ratio for 2015 is 82.5%. This calculation excludes regulatory fees and taxes. At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. As a result, we have not included an adjustment in the MLR calculation for these expenses. It is IUHP's intent to identify their Quality Improvement expenses for purposes of submitting their MLR-related filings and calculating related rebates, if any. The table below shows the calculation.

a)	Incurred Claims Net of Cost Sharing	$501.10
b)	Transitional Reinsurance Reimbursement	($51.43)
c)	Reinsurance Charge	$3.67
d)	Quality Improvement Expenses	$0.00
e)	Worksheet 1 Projected Incurred Claims (a+b+c+d)	$453.34
f)	Administrative Expenses	$82.21
g)	Profit & Risk Margin	$17.37
h)	Regulatory Taxes and Fees (excluding reinsurance charge)	$26.01
i)	Gross Premium (e+f+g+h)	$578.92
j)	Medical Loss Ratio (e/(i-c-h))	82.5%

12) Single Risk Pool

IUHP has not previously operated in the Individual market and thus does not have any claims experience to develop its own Single Risk Pool. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

13) Index Rate

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the Index Rate for the Experience Period has been left blank.

The Index Rate of $734.69 for the 2015 Projection Period represents the overall projected allowed costs PMPM for providing Essential Health Benefits for the Single Risk Pool. Since this is a new product, the index rate was developed based on a manual rate as described above in the Credibility Manual Rate Development section. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

14) Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic characteristics of the Single Risk Pool. In other words, the Market Adjusted Index Rate is not calibrated.

The development of the Federal reinsurance program and risk adjustments was described above in the Risk Adjustment and Reinsurance section. The development of the Exchange user fee adjustment was described above in the Non-Benefit Expenses and Profit & Risk section.

Index Rate	$734.69
Reinsurance Reimbursements (7.0% of Allowed Claims – Index Rate)	($51.43)
Reinsurance Premiums	$ 3.67
Risk Adjustment	$ 0.00
Exchange user fee (3.15% of average premium for Single Risk Pool)	$ 18.24
Market Adjusted Index Rate	$705.17

15) Plan Adjusted Index Rates

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the Part I Unified Rate Review Template in 2015. These Plan Adjusted Index Rates have been adjusted to remove the portion of the allowed cost that is expected to be recouped through the tobacco surcharge. The average tobacco surcharge for the Single Risk Pool is approximately 1.4%.

The Plan Adjusted Index Rates reflect the average demographic characteristics of the Single Risk Pool. In other words, the Plan Adjusted Index Rates are not calibrated.

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

- Actuarial value and cost sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)
- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

Only the actuarial value and cost sharing & distribution and administrative costs adjustments were applicable to IUHP.

Actuarial Value and Cost Sharing Adjustment

This adjustment includes three components:

- Removal of tobacco surcharge - the average tobacco surcharge factor was applied to the average allowed costs for the Single Risk Pool
- Benefit richness utilization adjustments - The reference plan underlying our pricing was a Silver plan. Benefit richness utilization adjustments were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge). These adjustments were based on the values published in the Federal Register payment notice, normalized to the Silver plan level. The adjustments for each metallic tier are as follows:
    - Bronze = 1.00 / 1.03 = 0.9709
    - Silver = 1.00 / 1.00 = 1.0000
    - Gold = 1.08 / 1.03 = 1.0485
- Cost Sharing - The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT was used to calculate the cost sharing percentage for each plan. These cost sharing percentages were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge and applying the benefit richness utilization adjustments). The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

Adjustment for Distribution and Administrative Costs

Fixed and variable costs as described in the Non-Benefit Expenses and Profit & Risk section were included in this adjustment as follows:

- Fixed costs: Risk adjustment user and PCORI fees
- Variable costs (% of premium): Administrative expenses, sales & marketing expenses, profit & risk margin, and premium taxes. The percentages applied did not vary by plan.

Appendix D shows the development of the Plan Adjusted Index Rates.

16) Calibration

The Plan Adjusted Index Rates (which are based on the Single Risk Pool) were calibrated to apply the allowable rating factors in order to calculate Consumer Adjusted Premium Rates. The calibration by age and geography is described below.

Age Curve Calibration

The methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology and conforms with the rating rules specified in 45 CFR 147.102.

The expected membership distribution by age band was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. A uniform distribution within each age band was also assumed. A weighted average age factor of 1.685 for the Single Risk Pool was also determined by applying the membership distribution to the Federal age curve. This represents a rounded weighted average age of 49. Appendix C shows the development of the weighted average age factor.

The Plan Index Rates were calibrated by dividing by 1.706 which represents the standard age factor of the rounded weighted average age of 49. This calibration factor does not vary by plan.

Geographic Factor Calibration

A geographic factor calibration was not required since the weighted average of the geographic factors equals 1.0. The Geographic (rating area) factors were developed based upon the network characteristics for unit cost and utilization management in each of the established rating areas. Based upon the expected distribution of enrolment by area, the area factors reflect the Single Risk Pool results consistent with the URRT.

Appendix D shows how the calibration adjustments were applied to the Plan Adjusted Index Rates.

17) Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate

is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography if necessary, and applying the rating factors specified by 45 CFR Part 147, §147.102. The following adjustments are allowable under this rule:

- Whether the plan coverage covers an individual or family (issuers must cover any eligible individual and/or eligible family that requests coverage per the guaranteed issue requirement of the ACA); this is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor
- Rating area
- Age – reflecting the applicable age curve
- Tobacco status

The rating factors (shown in Appendix C) are applied at an individual level and added together to calculate the family rate, with the exception that no more than 3 covered children under the age of 21 are charged a rate. Adjustment for family size is in accordance with Federal rules. The examples in Appendix E show how the rating factors are applied to the calibrated Plan Adjusted Index Rate.

18) AV Metal Values

The Federal AV calculator was used without any modifications to generate the Metal Values included in Worksheet 2 of the URRT. Please refer to Appendix F for screen shots showing the AV calculations for each plan.

19) AV Pricing Values

The Silver Value plan was selected as the fixed reference plan and serves as the basis for the AV Pricing Values. Please refer to Appendix C for the AV Pricing Values for each plan which are also included in Worksheet 2, Section I of the URRT. The AV Pricing Value for each plan reflects the relative impact of the plan's cost-sharing amounts, expected impact on enrollee utilization due to benefit richness (excluding impact of morbidity), expected additional cost of non-EHB, and administrative expenses (excluding health insurance exchange user fees).

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the PwC Rating Model as described above in the Credibility Manual Rate Development section was used to develop the benefit relativities for the AV Pricing Values.

20) Membership Projections

Membership projections were based on market penetration assumptions provided by IUHP. These assumptions reflected the uninsured and individual market populations by county, income level, and other characteristics such as the presence of IUHP facilities and delivery system within a given county.

The expected membership distribution by age band and metallic tier was based upon the Indiana

Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. For the Silver plans, the portion of the projected enrollment that will be eligible for CSR subsidies at each subsidy level was based on the income level detail in the market penetration analysis provided by IUHP.

Summaries of the projected membership by age, metallic tier, and CSR subsidy level are shown in Appendix B.

21) Terminated Products

Not applicable. IUHP does not currently have Individual plans in the State of Indiana.

22) Plan Type

All plans listed types in Worksheet 2, Section I of the URRT correctly describe IUHP's plans as "HMO".

23) Warning Alerts

Two warnings were generated in the URRT, both of which were due to adjustments to the Projected Incurred Claims between Worksheet 1 and Worksheet 2. The first adjustment was the removal of the impact of the tobacco surcharge of 1.4% as required in the reporting of the Plan Adjusted Index Rates and related items in Worksheet 2. This resulted in a decrease in Projected Incurred Claims of $10.00 PMPM between Worksheets 1 and 2. The second adjustment was the application of the induced utilization factors in the development of the Plan Adjusted Index Rate for each plan. When aggregated, the impact was a reduction of 0.5% or $3.22 PMPM.

24) Company Financial Position

Please see Appendix G for information regarding the capital and surplus position of IUHP.

25) Reliance

In the preparation of this filing, I have relied upon data provided by Eric Neuville (Vice President Product Development and Innovation), Connie Brown (CFO and COO), and IUHP management. I did not audit this data but did review it for reasonableness. This information includes but is not limited to the following items:

- Administrative expense projections
- Provider reimbursement levels (including capitation arrangements)
- Projected enrollment
- Projected pharmacy discounts, unit costs and rebates
- Financial statement information

26) Actuarial Certification

I, Robert Macagnano, FSA, MAAA, am affiliated with PricewaterhouseCoopers LLP (PwC). I am a Member of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinion contained herein. This filing is prepared on behalf of Indiana University Health Plans, Inc. (the "Company").

I certify that this filing has been prepared in accordance with the following Actuarial Standards of Practice (ASOP) including:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications

I certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

I certify that the Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

On/Off Exchange Attestation

I certify that a single set of premium rates was submitted with this filing which is applicable for all plans offered both on and off the Exchange, and that this assures the same premium rate will be charged without regard to whether the plan is offered through the Exchange or whether the plan is offered directly from the Company or through an agent.

QHP Off Exchange Premium Tax Credit (PTC) Attestation

To notify consumers that coverage purchased outside of the Exchange is not eligible for premium tax credit assistance, the Company will include the following language in their marketing materials:

"DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace."

This disclaimer is located on page 1 of the Company's policy form.

The Part I Unified Rate Review Template does not demonstrate the process used by the Company to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Respectfully submitted,



Robert Macagnano, FSA, MAAA
Director
(973) 236-4082
Robert.Macagnano@us.pwc.com

Appendix A
Indiana University Health Plans, Inc.
Plan Design Summaries

Plan Name	Deductible	OOP Max	Coinsurance	PCP Visit	Specialist Visit	ER Visit	Inpatient Stay	Rx - Retail	Rx - Mail Order
IU Health Plans Gold Value	$750/$1,500	$6,000/$12,000	20% after deductible	$20 copay	$50 copay before deductible and 20% after deductible	$200 copay then deductible and 20% coinsurance	$500 copay then deductible and 20% coinsurance	$8/$20/20%/30%/30% (coinsurance applies after deductible)	$24/$60/20%/30%/30% (coinsurance applies after deductible)
IU Health Plans Silver HSA	$2,750/$5,500	$3,600/$7,200	10% after deductible	10% after deductible	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% after deductible	$15/$45/25%/35%/35% after deductible
IU Health Plans Silver Value	$2,500/$5,000	$6,350/$12,700	10% after deductible	$40 copay	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Silver Enhanced	$2,000/$4,000	$5,750/$11,500	20% after deductible	$30 copay	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Bronze HSA	$4,500/$9,000	$6,350/$12,700	20% after deductible	20% after deductible	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$10/$25/30%/40%/40% after deductible	$30/$75/30%/40%/40% after deductible
IU Health Plans Bronze Value	$6,000/$12,000	$6,350/$12,700	25% after deductible	$40 copay	25% after deductible	$350 copay then deductible and 25% coinsurance	$1,500 copay then deductible and 25% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)
IU Health Plans Bronze Enhanced	$5,000/$10,000	$6,350/$12,700	40% after deductible	$50 copay before deductible and then 40% after deductible	40% after deductible	$275 copay then deductible and 40% coinsurance	$750 copay then deductible and 40% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area

Member Distribution by Age	
Age Band	**Membership Distribution**
0-20	10.15%
21	1.09%
22	1.09%
23	1.09%
24	1.09%
25	1.09%
26	1.85%
27	1.85%
28	1.85%
29	1.85%
30	1.85%
31	1.85%
32	1.85%
33	1.85%
34	1.85%
35	1.68%
36	1.68%
37	1.68%
38	1.68%
39	1.68%
40	1.68%
41	1.68%
42	1.68%
43	1.68%
44	1.68%
45	2.12%
46	2.12%
47	2.12%
48	2.12%
49	2.12%
50	2.12%
51	2.12%
52	2.12%
53	2.12%
54	2.12%
55	2.98%
56	2.98%
57	2.98%
58	2.98%
59	2.98%
60	2.98%
61	2.98%
62	2.98%
63	2.98%
64	2.98%
65 and over	0.00%

Membership Distribution by Rating Area	
Rating Area	**Membership Distribution**
5	4.5%
7	30.9%
8	17.7%
10	9.0%
11	2.9%
13	29.9%
15	5.1%
Total	**100.0%**

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area
(continued)

		Silver					
Plan Name	**Gold**	**70**	**CSR 73**	**CSR 87**	**CSR 94**	**Bronze**	**Total**
IU Health Plans Gold Value	73						73
IU Health Plans Silver HSA		28	-	-	-		28
IU Health Plans Silver Value		168	152	284	69		673
IU Health Plans Silver Enhanced		84	76	142	35		337
IU Health Plans Bronze HSA						35	35
IU Health Plans Bronze Value						210	210
IU Health Plans Bronze Enhanced						105	105
Total	73	280	229	426	104	351	1,462

Appendix C
Indiana University Health Plans, Inc.
Rating Factors

Age-Based Tobacco Factors		
Age	**Smoker**	**Non-smoker**
0-20	1.000	1.000
21	1.050	1.000
22	1.050	1.000
23	1.050	1.000
24	1.050	1.000
25	1.050	1.000
26	1.050	1.000
27	1.050	1.000
28	1.050	1.000
29	1.050	1.000
30	1.050	1.000
31	1.070	1.000
32	1.090	1.000
33	1.110	1.000
34	1.130	1.000
35	1.150	1.000
36	1.170	1.000
37	1.190	1.000
38	1.210	1.000
39	1.230	1.000
40	1.250	1.000
41	1.270	1.000
42	1.290	1.000
43	1.310	1.000
44	1.330	1.000
45	1.350	1.000
46	1.370	1.000
47	1.390	1.000
48	1.410	1.000
49	1.430	1.000
50	1.450	1.000
51	1.470	1.000
52	1.490	1.000
53	1.490	1.000
54	1.473	1.000
55	1.410	1.000
56	1.348	1.000
57	1.290	1.000
58	1.234	1.000
59	1.208	1.000
60	1.158	1.000
61	1.118	1.000
62	1.094	1.000
63	1.065	1.000
64	1.048	1.000
65 and over	1.048	1.000

Federal Age Curve		
Age Band	**Membership Distribution**	**Age Factor**
0-20	10.15%	0.635
21	1.09%	1.000
22	1.09%	1.000
23	1.09%	1.000
24	1.09%	1.000
25	1.09%	1.004
26	1.85%	1.024
27	1.85%	1.048
28	1.85%	1.087
29	1.85%	1.119
30	1.85%	1.135
31	1.85%	1.159
32	1.85%	1.183
33	1.85%	1.198
34	1.85%	1.214
35	1.68%	1.222
36	1.68%	1.230
37	1.68%	1.238
38	1.68%	1.246
39	1.68%	1.262
40	1.68%	1.278
41	1.68%	1.302
42	1.68%	1.325
43	1.68%	1.357
44	1.68%	1.397
45	2.12%	1.444
46	2.12%	1.500
47	2.12%	1.563
48	2.12%	1.635
49	2.12%	1.706
50	2.12%	1.786
51	2.12%	1.865
52	2.12%	1.952
53	2.12%	2.040
54	2.12%	2.135
55	2.98%	2.230
56	2.98%	2.333
57	2.98%	2.437
58	2.98%	2.548
59	2.98%	2.603
60	2.98%	2.714
61	2.98%	2.810
62	2.98%	2.873
63	2.98%	2.952
64	2.98%	3.000
65 and over	0.00%	3.000
Weighted average age factor		1.685

Appendix C
Indiana University Health Plans, Inc.
Rating Factors
(continued)

Geographic Factors		
Rating Area	**Membership Distribution**	**Rating Area Factor**
5	4.5%	0.976
7	30.9%	0.976
8	17.7%	1.006
10	9.0%	1.060
11	2.9%	0.972
13	29.9%	1.010
15	5.1%	0.998
Total	**100.0%**	**1.000**

Plan Value Factors	
Plan Name	**Pricing Value**
IU Health Plans Gold Value	1.191
IU Health Plans Silver HAS	0.992
IU Health Plans Silver Value	1.000
IU Health Plans Silver Enhanced	1.009
IU Health Plans Bronze HAS	0.823
IU Health Plans Bronze Value	0.845
IU Health Plans Bronze Enhanced	0.855

Appendix D
Indiana University Health Plans, Inc.
Plan Adjusted Index Rate Development

Plan Name	Market adjusted index rate (a)	Actuarial value and cost sharing adjustment (b)	Adjustment for distribution and administrative costs (c)	Plan adjusted index rate (d) = (a) + (b) + (c)	Age calibration (e)	Geographic calibration (f)	Calibrated base rate (g) = (d) / [(e) x (f)]
IU Health Plans Gold Value	$ 705.17	$(139.80)	$128.75	$694.12	1.706	1.000	$406.87
IU Health Plans Silver HSA	$ 705.17	$(234.52)	$107.04	$577.69	1.706	1.000	$338.62
IU Health Plans Silver Value	$ 705.17	$(230.51)	$107.95	$582.61	1.706	1.000	$341.51
IU Health Plans Silver Enhanced	$ 705.17	$(226.33)	$108.90	$587.74	1.706	1.000	$344.51
IU Health Plans Bronze HSA	$ 705.17	$(314.62)	$88.73	$479.28	1.706	1.000	$280.94
IU Health Plans Bronze Value	$ 705.17	$(304.07)	$91.13	$492.22	1.706	1.000	$288.52
IU Health Plans Bronze Enhanced	$ 705.17	$(299.15)	$92.24	$498.26	1.706	1.000	$292.06

Appendix E
Indiana University Health Plans, Inc.
Rating Examples

Selected Plan:	IU Health Plans Silver Value
Rating Area:	Rating Area 11

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$341.51	0.972	2.230	1.410	$1,043.86
Spouse	40	Non-Smoker	$341.51	0.972	1.278	1.000	$424.28
Child 1	18	Non-Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 2	15	Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 3	13	Non-Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 4	10	Non-Smoker	$341.51	0.972	0.635	1.000	$0.00
Total Premium							$2,100.57

Selected Plan:	IU Health Plans Gold Value
Rating Area:	Rating Area 7

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$406.87	0.976	2.230	1.410	$1,248.39
Spouse	40	Non-Smoker	$406.87	0.976	1.278	1.000	$507.41
Child 1	18	Non-Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 2	15	Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 3	13	Non-Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 4	10	Non-Smoker	$406.87	0.976	0.635	1.000	$0.00
Total Premium							$2,512.14

Appendix F
Indiana University Health Plans, Inc.
Federal AV Calculator Results

IU Health Plans Gold Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☑		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.80	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.4%
Metal Tier:	Gold

IU Health Plans Silver HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.0%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.1%
Metal Tier:	Gold

IU Health Plans Silver HSA - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$400.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.1%
Metal Tier:	Platinum

IU Health Plans Silver Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.4%
Metal Tier:	Gold

IU Health Plans Silver Value - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

IU Health Plans Silver Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.7%
Metal Tier:	Gold

IU Health Plans Silver Enhanced - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$150.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$650.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

IU Health Plans Bronze HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.6%
Metal Tier:	Bronze

IU Health Plans Bronze Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	**Drug**	**Combined**	**Medical**	**Drug**	**Combined**
		$6,000.00			
		75.00%			
		$6,350.00			

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$350.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze

IU Health Plans Bronze Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,350.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$275.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☑		$50.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.8%
Metal Tier:	Bronze

Appendix G
Indiana University Health Plans, Inc.
Capital, Surplus, and RBC Information

Annual Statement for the year 2013 of the Indiana University Health Plans, Inc.

ASSETS

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1. Bonds (Schedule D)				
2. Stocks (Schedule D):				
2.1 Preferred stocks				
2.2 Common stocks				
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens				
3.2 Other than first liens				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ encumbrances)				
4.2 Properties held for the production of income (less $ encumbrances)				
4.3 Properties held for sale (less $ encumbrances)				
5. Cash ($ 6,645,144, Schedule E - Part 1), cash equivalents ($, Schedule E - Part 2), and short-term investments ($, Schedule DA)	6,645,144		6,645,144	8,006,798
6. Contract loans (including $ premium notes)				
7. Derivatives (Schedule DB)				
8. Other invested assets (Schedule BA)				
9. Receivables for securities				
10. Securities lending reinvested collateral assets (Schedule DL)				
11. Aggregate write-ins for invested assets				
12. Subtotals, cash and invested assets (Lines 1 to 11)	6,645,144		6,645,144	8,006,798
13. Title plants less $ charged off (for Title insurers only)				
14. Investment income due and accrued	1,068		1,068	2,137
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	231,209	66,791	164,418	201,607
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ earned but unbilled premiums)				
15.3 Accrued retrospective premiums				
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers				
16.2 Funds held by or deposited with reinsured companies				
16.3 Other amounts receivable under reinsurance contracts				
17. Amounts receivable relating to uninsured plans				
18.1 Current federal and foreign income tax recoverable and interest thereon				
18.2 Net deferred tax asset				
19. Guaranty funds receivable or on deposit				
20. Electronic data processing equipment and software				
21. Furniture and equipment, including health care delivery assets ($)				
22. Net adjustment in assets and liabilities due to foreign exchange rates				
23. Receivables from parent, subsidiaries and affiliates	332,038		332,038	714,499
24. Health care ($ 449,493) and other amounts receivable	1,838,476	915,716	922,760	616,348
25. Aggregate write-ins for other than invested assets	1,110,648	156,922	953,726	510,111
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	10,158,583	1,139,429	9,019,154	10,051,500
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28. Total (Lines 26 and 27)	10,158,583	1,139,429	9,019,154	10,051,500

DETAILS OF WRITE-IN LINES				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	NONE			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501. Estimated Medicare Settlement Receivable	953,726		953,726	510,111
2502. Prepaid General and Administrative Expenses	156,922	156,922		
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page				
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	1,110,648	156,922	953,726	510,111

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ 0 reinsurance ceded)				
2.	Accrued medical incentive pool and bonus amounts				
3.	Unpaid claims adjustment expenses				
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Services Act	29,399		29,399	105,075
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	294,066		294,066	229,823
9.	General expenses due or accrued	818,192		818,192	1,431,649
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))				
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others				
13.	Remittances and items not allocated				
14.	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)				
15.	Amounts due to parent, subsidiaries and affiliates				12,550
16.	Derivatives				
17.	Payable for securities				
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified $ (0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans				
23.	Aggregate write-ins for other liabilities (including $ 0 current)	595,407		595,407	871,800
24.	Total liabilities (Lines 1 to 23)	1,737,064		1,737,064	2,650,897
25.	Aggregate write-ins for special surplus funds	XXX	XXX		
26.	Common capital stock	XXX	XXX	1,000	1,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	27,499,000	27,999,000
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	(20,217,910)	(20,599,397)
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX		
	32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	7,282,090	7,400,603
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	9,019,154	10,051,500

	DETAILS OF WRITE-IN LINES				
2301.	Estimated Medicare Settlement Liability	338,139		338,139	667,855
2302.	Other Amounts Payable	257,268		257,268	203,945
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	595,407		595,407	871,800
2501.		XXX	XXX		
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

NONE

NONE

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL - XR025

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		7,282,090	
(2)	Company Action Level=200% of Authorized Control Level	CAL	4,146,860	
(3)	Regulatory Action Level=150% of Authorized Control Level	RAL	3,110,145	
(4)	Authorized Control Level=100% of Authorized Control Level	ACL	2,073,430	
(5)	Mandatory Control Level=70% of Authorized Control Level	MCL	1,451,401	
(6)	Level of Action, if Any		NONE	

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	7,282,090
Authorized Control Level Risk-Based Capital on Line 15 of the Five Year Historical Data Page	2,073,430

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	98,250,957	
(8)	Underwriting Deductions	Page 4, Line 23	97,709,883	
(9)	Combined Ratio	Line (8)/Line(7)	99.400	
(10)	RBC Ratio	Line(1)/Line(4)	351.200	
(11)	Trend Test Result	If Line(10) is between 200% and 300% and Line (9) > 105%, then "Yes", otherwise "No"		No
(12)	Level of Action, if any, including Trend Test		NONE	

Actuarial Memorandum

Indiana University Health Plans, Inc.

Individual Health Rate Filing

Effective January 1, 2015 through December 31, 2015

Form: 13164.1-Indiv-Policy-Adult (01/2015)

13164.1-Indiv-Policy-Child (01/2015)

Submitted: May 9, 2014

TABLE OF CONTENTS

1) General Information 3
2) Proposed Rate Increase(s) 4
3) Experience Period Premium and Claims 4
4) Benefit Categories 5
5) Projection Factors 5
6) Credibility Manual Rate Development 5
7) Credibility of Experience 7
8) Paid to Allowed Ratio 7
9) Risk Adjustment and Reinsurance 8
10) Non-Benefit Expenses and Profit & Risk 8
11) Projected Loss Ratio 9
12) Single Risk Pool 10
13) Index Rate 10
14) Market Adjusted Index Rate 10
15) Plan Adjusted Index Rates 11
16) Calibration 12
17) Consumer Adjusted Premium Rate Development 12
18) AV Metal Values 13
19) AV Pricing Values 13
20) Membership Projections 13
21) Terminated Products 14
22) Plan Type 14
23) Warning Alerts 14
24) Company Financial Position 14
25) Reliance 14
26) Actuarial Certification 15

1) General Information

Overview

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template (URRT), which supports compliance with the market rating rules and reasonableness of applicable rate increases.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with State of Indiana statutes and provisions of the Affordable Care Act (ACA). This memorandum documents the development of the Individual rates for Indiana University Health Plans, Inc. (IUHP). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This information may not be appropriate for other purposes.

This information is intended for use by the State of Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of IUHP's Individual rate filing. However, we recognize that this certification may become a public document. PwC makes no representations or warranties regarding the contents of this memorandum to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for IUHP by PwC that would result in the creation of any duty or liability under any theory of law by PwC or its employees to third parties.

These results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

Company Identifying Information

- Company Legal Name: Indiana University Health Plans, Inc.
- State: The State of Indiana has regulatory authority over these policies
- HIOS Issuer ID: 33380
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: Eric Neuville, Vice President Product Development and Innovation
- Primary Contact Telephone Number: (317) 963-1835
- Primary Contact Email Address: eneuville@iuhealth.org

Certifying Actuary Contact Information

- Primary Contact Name: Robert Macagnano, PwC
- Primary Contact Telephone Number: (973) 236-4082
- Primary Contact Email Address: robert.macagnano@us.pwc.com

Benefit Summary

IUHP will be offering three Bronze, three Silver, and one Gold HMO products. A summary of the major provisions of each plan are provided in Appendix A.

Premium Guarantee Provision

Premiums are guaranteed not to change through December 31, 2015.

Renewability

The policy is renewable by paying the applicable renewal premiums unless the policyholder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability

The rates will apply to new business. Subsequent renewal business will be subject to rates filed for our 2016 rate development.

Premium Modalization

Premiums will be collected only on a monthly basis.

Trend Assumption

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2) Proposed Rate Increase(s)

This is a new filing therefore no rate increase assumption is included in this filing. Subsequent rate increases beginning with effective dates of January 1, 2016 will be filed in the future.

3) Experience Period Premium and Claims

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

4) Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.

Capitation: Includes capitated services for pediatric vision benefits.

Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

5) Projection Factors

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6) Credibility Manual Rate Development

The PwC Rating Model was used as the basis to develop the manual rates. Our model was developed using two primary sources:

- Commercial Truven Health MarketScan® Research Databases for U.S. members and providers. The database contains full enrollment and claims information with standard medical coding which allows for cost and utilization information by service category (inpatient, outpatient hospital, hospice, home health, professional, prescription drugs, etc.). The database consists of the experience from 53 million Commercial eligible participants. The data can be extracted down to the member's state and MSA level. For the Indiana Commercial market, there were approximately 1.5 million exposed life years' worth of data crossing all ages, genders and employment statuses (active, COBRA, disabled and retired). Nationwide, the databases have over 100 unique data contributors so it is not skewed to any one payer.
- OptumInsight (Optum) Comprehensive Pricing Model® provides benchmark data and pricing capabilities for Commercial health plans. It factors in health plan features such as

deductibles, copays, out-of-pocket maximums, covered services, etc. The model uses normative data and benefit details to arrive at an allowed cost per member per month. The normative benchmarking utilization metrics within the model are developed from Optum's database of Commercial (under 65) health plan experience of approximately 20 million life years. The model experience was adjusted to reflect the Indiana marketplace.

Since both the Truven and Optum data sources represent fully-completed calendar year 2012 claims, allowed costs were trended to the midpoint of calendar year 2015 using an annual trend rate of 7.4%.

The allowed costs component of the manual rates was increased by 2% to account for expected changes in covered benefits due to the Essential Health Benefits (EHB) requirements. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- State mandated benefits included in the EHB that previously only applied to group coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

The manual rates were increased by 15% to reflect the entrance of approximately 7,000 Medicaid Spend-Down beneficiaries into the Indiana Health Insurance Exchange. This adjustment was based on the assumption that IUHP's penetration of the Medicaid Spend-Down population would be similar to their assumed penetration of the general population. Expenditure information for the Medicaid Spend-Down population was provided by the Indiana Family and Social Services Administration and contained in the April 21, 2014 study "Spend Down Exchange Impact: Transition to the Indiana Health Insurance Exchange" performed by Milliman, Inc. In addition, preliminary estimates provided by the Indiana Department of Insurance (IDOI) during their May 2, 2014 Weekly ACA Rate & Form Filing Call Session indicated that the inclusion of this population would increase premiums by 5% - 15%. We have been informed by the IDOI that additional information pertaining to this population will be made available. We reserve the right to revise our filing to reflect this data subsequent to this filing.

There will also be new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services. Pent up demand has been shown to increase costs in the first year of enrollment for those previously uninsured. Based on analysis of programs serving a similar population, it appears that the claims are higher in the first six to 12 months that an individual is newly insured. After this initial period, the claims experience tends to revert to the average level for the market. The total effect is uncertain and may be offset by some new enrollees having reduced utilization as they may not fully

understand new or increased coverage. Therefore, we have included an adjustment within our manual rate development for pent up demand of 5.0%.

The following adjustments were made to calibrate the pricing model to the expected population:

- Rating region
- Expected demographics
- Expected morbidity
- Contractual Agreements with healthcare providers
- Expected utilization management savings
- Benefit plan designs

Some benefits will be reimbursed under a capitation arrangement. The provider reimbursement adjustment to the pricing model was developed to account for the cost of capitated services.

The manual rates were also adjusted upward by a factor of 1.005 to account for the likelihood that some enrollees may not pay their premiums due during the first month of the 90-day grace period. This was calculated assuming a 15% rate of non-payment on one-twelfth of the annual premium due for 80% of the Individual population (those eligible for Advance Payments of a Premium Tax Credit). The amount of premium at risk is only on the portion that IUHP does not receive via direct subsidy, estimated to be 50% (0.15 x 1/12 x 0.80 x 0.50 = 0.005). The 15% represents our assumption regarding the small portion of enrollees that we believe will knowingly take advantage of the grace period provision. The 80% represents the portion of enrollees in the 2015 Individual marketplace that we assume will be eligible for premium subsidies based on income level. On May 1, 2014 the Department of Health and Human Services reported that as of April 19, 2014, 89% of those enrolled in the Indiana exchange were eligible for federal assistance. Our assumption is that this percentage will decrease during 2015.

7) Credibility of Experience

IUHP has not previously operated in the individual market. As a result the “Experience Period” section of Worksheet 1 of the URRT has not been populated. Similarly, the projection factors (cells J24:M29 on Worksheet 1) have also been left blank. The service category PMPMs shown in the “Credibility Manual” section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

8) Paid to Allowed Ratio

The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT calculates the PMPM costs on both an allowed and paid basis. The “Paid to Allowed Average Factor in Projection Period” shown on Worksheet 1, Section III of the URRT is developed by membership-weighted EHB paid claims divided by membership-weighted EHB allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

9) Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, IUHP is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value. Therefore, no risk adjustment PMPM payment is assumed for 2015.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only)

The Federal transitional reinsurance program is a temporary risk mitigation program expected to reduce costs for insurance issuers. The 2015 reinsurance program has an attachment point of $70,000 and a maximum coverage limit of $250,000 per member. The Department of Health and Human Services will reimburse insurance issuers 50% of paid costs between the attachment point and maximum coverage limit.

Allowed claims were reduced by 7.0% to account for the anticipated 2015 reimbursements from this temporary program. This estimate was developed using projected paid claims, a claims probability distribution calibrated to the expected average claim levels for the 2015 Individual market, and the federal program guidelines summarized above. The expected reinsurance reimbursements of $51.43 PMPM are allocated proportionally by plan based on allowed claims. Applying the 2015 transitional reinsurance charge of $3.67 PMPM yields a net reinsurance cost of $47.76 PMPM.

Projected Net Cost of Private Reinsurance

The projected net cost of private reinsurance for 2015 is $0.00 PMPM since IUHP does not intend to purchase private reinsurance.

10) Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

IUHP developed their expected administrative expenses based on: a) current administrative expenses for their Medicare line of business adjusting for any expected differences for their Commercial products, and b) a review of 2014 Rate Filings for Individual Exchange products. A summary of IUHP's assumptions is as follows:

- Administrative expenses (excluding Sales and Marketing expenses): 10.50% of premium
- Sales and Marketing expenses (including commissions): 3.70% of premium

These administrative expenses are allocated proportionally by plan.

Quality Improvement Expenses

At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. Therefore, no explicit Quality Improvement expenses were assumed.

Profit & Risk Margin

The proposed rates reflect a profit & risk margin of 3.0% of premium. This load was applied to all products and plans.

Taxes and Fees

A summary of the assumed taxes and fees are summarized below:

PMPM Basis

- Transitional reinsurance charge: $3.67 PMPM ($44.00 per member per year)
- Risk adjustment user fee: $0.08 PMPM
- PCORI fee: $0.17 PMPM ($2.00 per member per year)

Percentage of Premium Basis

- Health insurance exchange fee: 3.15% of premium reflecting IUHP's assumption that 90% of their expected 2015 business will be sold through the exchange
- ACA issuer fee: IUHP will not be subject to this fee for 2015
- Premium tax: 1.30% of premium

11) Projected Loss Ratio

The overall projected medical loss ratio for 2015 is 82.5%. This calculation excludes regulatory fees and taxes. At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. As a result, we have not included an adjustment in the MLR calculation for these expenses. It is IUHP's intent to identify their Quality Improvement expenses for purposes of submitting their MLR-related filings and calculating related rebates, if any. The table below shows the calculation.

a)	Incurred Claims Net of Cost Sharing	$501.10
b)	Transitional Reinsurance Reimbursement	($51.43)
c)	Reinsurance Charge	$3.67
d)	Quality Improvement Expenses	$0.00
e)	Worksheet 1 Projected Incurred Claims (a+b+c+d)	$453.34
f)	Administrative Expenses	$82.21
g)	Profit & Risk Margin	$17.37
h)	Regulatory Taxes and Fees (excluding reinsurance charge)	$26.01
i)	Gross Premium (e+f+g+h)	$578.92
j)	Medical Loss Ratio (e/(i-c-h))	82.5%

12) Single Risk Pool

IUHP has not previously operated in the Individual market and thus does not have any claims experience to develop its own Single Risk Pool. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

13) Index Rate

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the Index Rate for the Experience Period has been left blank.

The Index Rate of $734.69 for the 2015 Projection Period represents the overall projected allowed costs PMPM for providing Essential Health Benefits for the Single Risk Pool. Since this is a new product, the index rate was developed based on a manual rate as described above in the Credibility Manual Rate Development section. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

14) Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic characteristics of the Single Risk Pool. In other words, the Market Adjusted Index Rate is not calibrated.

The development of the Federal reinsurance program and risk adjustments was described above in the Risk Adjustment and Reinsurance section. The development of the Exchange user fee adjustment was described above in the Non-Benefit Expenses and Profit & Risk section.

Index Rate	$734.69
Reinsurance Reimbursements (7.0% of Allowed Claims – Index Rate)	($51.43)
Reinsurance Premiums	$ 3.67
Risk Adjustment	$ 0.00
Exchange user fee (3.15% of average premium for Single Risk Pool)	$ 18.24
Market Adjusted Index Rate	$705.17

15) Plan Adjusted Index Rates

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the Part I Unified Rate Review Template in 2015. These Plan Adjusted Index Rates have been adjusted to remove the portion of the allowed cost that is expected to be recouped through the tobacco surcharge. The average tobacco surcharge for the Single Risk Pool is approximately 1.4%.

The Plan Adjusted Index Rates reflect the average demographic characteristics of the Single Risk Pool. In other words, the Plan Adjusted Index Rates are not calibrated.

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

- Actuarial value and cost sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)
- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

Only the actuarial value and cost sharing & distribution and administrative costs adjustments were applicable to IUHP.

Actuarial Value and Cost Sharing Adjustment

This adjustment includes three components:

- Removal of tobacco surcharge - the average tobacco surcharge factor was applied to the average allowed costs for the Single Risk Pool
- Benefit richness utilization adjustments - The reference plan underlying our pricing was a Silver plan. Benefit richness utilization adjustments were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge). These adjustments were based on the values published in the Federal Register payment notice, normalized to the Silver plan level. The adjustments for each metallic tier are as follows:
    - Bronze = 1.00 / 1.03 = 0.9709
    - Silver = 1.00 / 1.00 = 1.0000
    - Gold = 1.08 / 1.03 = 1.0485
- Cost Sharing - The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT was used to calculate the cost sharing percentage for each plan. These cost sharing percentages were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge and applying the benefit richness utilization adjustments). The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

Adjustment for Distribution and Administrative Costs

Fixed and variable costs as described in the Non-Benefit Expenses and Profit & Risk section were included in this adjustment as follows:

- Fixed costs: Risk adjustment user and PCORI fees
- Variable costs (% of premium): Administrative expenses, sales & marketing expenses, profit & risk margin, and premium taxes. The percentages applied did not vary by plan.

Appendix D shows the development of the Plan Adjusted Index Rates.

16) Calibration

The Plan Adjusted Index Rates (which are based on the Single Risk Pool) were calibrated to apply the allowable rating factors in order to calculate Consumer Adjusted Premium Rates. The calibration by age and geography is described below.

Age Curve Calibration

The methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology and conforms with the rating rules specified in 45 CFR 147.102.

The expected membership distribution by age band was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. A uniform distribution within each age band was also assumed. A weighted average age factor of 1.685 for the Single Risk Pool was also determined by applying the membership distribution to the Federal age curve. This represents a rounded weighted average age of 49. Appendix C shows the development of the weighted average age factor.

The Plan Index Rates were calibrated by dividing by 1.706 which represents the standard age factor of the rounded weighted average age of 49. This calibration factor does not vary by plan.

Geographic Factor Calibration

A geographic factor calibration was not required since the weighted average of the geographic factors equals 1.0. The Geographic (rating area) factors were developed based upon the network characteristics for unit cost and utilization management in each of the established rating areas. Based upon the expected distribution of enrolment by area, the area factors reflect the Single Risk Pool results consistent with the URRT.

Appendix D shows how the calibration adjustments were applied to the Plan Adjusted Index Rates.

17) Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate

is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography if necessary, and applying the rating factors specified by 45 CFR Part 147, §147.102. The following adjustments are allowable under this rule:

- Whether the plan coverage covers an individual or family (issuers must cover any eligible individual and/or eligible family that requests coverage per the guaranteed issue requirement of the ACA); this is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor
- Rating area
- Age – reflecting the applicable age curve
- Tobacco status

The rating factors (shown in Appendix C) are applied at an individual level and added together to calculate the family rate, with the exception that no more than 3 covered children under the age of 21 are charged a rate. Adjustment for family size is in accordance with Federal rules. The examples in Appendix E show how the rating factors are applied to the calibrated Plan Adjusted Index Rate.

18) AV Metal Values

The Federal AV calculator was used without any modifications to generate the Metal Values included in Worksheet 2 of the URRT. Please refer to Appendix F for screen shots showing the AV calculations for each plan.

19) AV Pricing Values

The Silver Value plan was selected as the fixed reference plan and serves as the basis for the AV Pricing Values. Please refer to Appendix C for the AV Pricing Values for each plan which are also included in Worksheet 2, Section I of the URRT. The AV Pricing Value for each plan reflects the relative impact of the plan's cost-sharing amounts, expected impact on enrollee utilization due to benefit richness (excluding impact of morbidity), expected additional cost of non-EHB, and administrative expenses (excluding health insurance exchange user fees).

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the PwC Rating Model as described above in the Credibility Manual Rate Development section was used to develop the benefit relativities for the AV Pricing Values.

20) Membership Projections

Membership projections were based on market penetration assumptions provided by IUHP. These assumptions reflected the uninsured and individual market populations by county, income level, and other characteristics such as the presence of IUHP facilities and delivery system within a given county.

The expected membership distribution by age band and metallic tier was based upon the Indiana

Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. For the Silver plans, the portion of the projected enrollment that will be eligible for CSR subsidies at each subsidy level was based on the income level detail in the market penetration analysis provided by IUHP.

Summaries of the projected membership by age, metallic tier, and CSR subsidy level are shown in Appendix B.

21) Terminated Products

Not applicable. IUHP does not currently have Individual plans in the State of Indiana.

22) Plan Type

All plans listed types in Worksheet 2, Section I of the URRT correctly describe IUHP's plans as "HMO".

23) Warning Alerts

Two warnings were generated in the URRT, both of which were due to adjustments to the Projected Incurred Claims between Worksheet 1 and Worksheet 2. The first adjustment was the removal of the impact of the tobacco surcharge of 1.4% as required in the reporting of the Plan Adjusted Index Rates and related items in Worksheet 2. This resulted in a decrease in Projected Incurred Claims of $10.00 PMPM between Worksheets 1 and 2. The second adjustment was the application of the induced utilization factors in the development of the Plan Adjusted Index Rate for each plan. When aggregated, the impact was a reduction of 0.5% or $3.22 PMPM.

24) Company Financial Position

Please see Appendix G for information regarding the capital and surplus position of IUHP.

25) Reliance

In the preparation of this filing, I have relied upon data provided by Eric Neuville (Vice President Product Development and Innovation), Connie Brown (CFO and COO), and IUHP management. I did not audit this data but did review it for reasonableness. This information includes but is not limited to the following items:

- Administrative expense projections
- Provider reimbursement levels (including capitation arrangements)
- Projected enrollment
- Projected pharmacy discounts, unit costs and rebates
- Financial statement information

26) Actuarial Certification

I, Robert Macagnano, FSA, MAAA, am affiliated with PricewaterhouseCoopers LLP (PwC). I am a Member of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinion contained herein. This filing is prepared on behalf of Indiana University Health Plans, Inc. (the "Company").

I certify that this filing has been prepared in accordance with the following Actuarial Standards of Practice (ASOP) including:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications

I certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

I certify that the Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

On/Off Exchange Attestation

I certify that a single set of premium rates was submitted with this filing which is applicable for all plans offered both on and off the Exchange, and that this assures the same premium rate will be charged without regard to whether the plan is offered through the Exchange or whether the plan is offered directly from the Company or through an agent.

QHP Off Exchange Premium Tax Credit (PTC) Attestation

To notify consumers that coverage purchased outside of the Exchange is not eligible for premium tax credit assistance, the Company will include the following language in their marketing materials:

"DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace."

This disclaimer is located on page 1 of the Company's policy form.

The Part I Unified Rate Review Template does not demonstrate the process used by the Company to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Respectfully submitted,



Robert Macagnano, FSA, MAAA
Director
(973) 236-4082
Robert.Macagnano@us.pwc.com

Appendix A
Indiana University Health Plans, Inc.
Plan Design Summaries

Plan Name	Deductible	OOP Max	Coinsurance	PCP Visit	Specialist Visit	ER Visit	Inpatient Stay	Rx - Retail	Rx - Mail Order
IU Health Plans Gold Value	$750/$1,500	$6,000/$12,000	20% after deductible	$20 copay	$50 copay before deductible and 20% after deductible	$200 copay then deductible and 20% coinsurance	$500 copay then deductible and 20% coinsurance	$8/$20/20%/30%/30% (coinsurance applies after deductible)	$24/$60/20%/30%/30% (coinsurance applies after deductible)
IU Health Plans Silver HSA	$2,750/$5,500	$3,600/$7,200	10% after deductible	10% after deductible	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% after deductible	$15/$45/25%/35%/35% after deductible
IU Health Plans Silver Value	$2,500/$5,000	$6,350/$12,700	10% after deductible	$40 copay	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Silver Enhanced	$2,000/$4,000	$5,750/$11,500	20% after deductible	$30 copay	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Bronze HSA	$4,500/$9,000	$6,350/$12,700	20% after deductible	20% after deductible	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$10/$25/30%/40%/40% after deductible	$30/$75/30%/40%/40% after deductible
IU Health Plans Bronze Value	$6,000/$12,000	$6,350/$12,700	25% after deductible	$40 copay	25% after deductible	$350 copay then deductible and 25% coinsurance	$1,500 copay then deductible and 25% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)
IU Health Plans Bronze Enhanced	$5,000/$10,000	$6,350/$12,700	40% after deductible	$50 copay before deductible and then 40% after deductible	40% after deductible	$275 copay then deductible and 40% coinsurance	$750 copay then deductible and 40% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area

Member Distribution by Age	
Age Band	**Membership Distribution**
0-20	10.15%
21	1.09%
22	1.09%
23	1.09%
24	1.09%
25	1.09%
26	1.85%
27	1.85%
28	1.85%
29	1.85%
30	1.85%
31	1.85%
32	1.85%
33	1.85%
34	1.85%
35	1.68%
36	1.68%
37	1.68%
38	1.68%
39	1.68%
40	1.68%
41	1.68%
42	1.68%
43	1.68%
44	1.68%
45	2.12%
46	2.12%
47	2.12%
48	2.12%
49	2.12%
50	2.12%
51	2.12%
52	2.12%
53	2.12%
54	2.12%
55	2.98%
56	2.98%
57	2.98%
58	2.98%
59	2.98%
60	2.98%
61	2.98%
62	2.98%
63	2.98%
64	2.98%
65 and over	0.00%

Membership Distribution by Rating Area	
Rating Area	**Membership Distribution**
5	4.5%
7	30.9%
8	17.7%
10	9.0%
11	2.9%
13	29.9%
15	5.1%
Total	**100.0%**

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area
(continued)

		Silver					
Plan Name	**Gold**	**70**	**CSR 73**	**CSR 87**	**CSR 94**	**Bronze**	**Total**
IU Health Plans Gold Value	73						73
IU Health Plans Silver HSA		28	-	-	-		28
IU Health Plans Silver Value		168	152	284	69		673
IU Health Plans Silver Enhanced		84	76	142	35		337
IU Health Plans Bronze HSA						35	35
IU Health Plans Bronze Value						210	210
IU Health Plans Bronze Enhanced						105	105
Total	73	280	229	426	104	351	1,462

Appendix C
Indiana University Health Plans, Inc.
Rating Factors

Age-Based Tobacco Factors		
Age	**Smoker**	**Non-smoker**
0-20	1.000	1.000
21	1.050	1.000
22	1.050	1.000
23	1.050	1.000
24	1.050	1.000
25	1.050	1.000
26	1.050	1.000
27	1.050	1.000
28	1.050	1.000
29	1.050	1.000
30	1.050	1.000
31	1.070	1.000
32	1.090	1.000
33	1.110	1.000
34	1.130	1.000
35	1.150	1.000
36	1.170	1.000
37	1.190	1.000
38	1.210	1.000
39	1.230	1.000
40	1.250	1.000
41	1.270	1.000
42	1.290	1.000
43	1.310	1.000
44	1.330	1.000
45	1.350	1.000
46	1.370	1.000
47	1.390	1.000
48	1.410	1.000
49	1.430	1.000
50	1.450	1.000
51	1.470	1.000
52	1.490	1.000
53	1.490	1.000
54	1.473	1.000
55	1.410	1.000
56	1.348	1.000
57	1.290	1.000
58	1.234	1.000
59	1.208	1.000
60	1.158	1.000
61	1.118	1.000
62	1.094	1.000
63	1.065	1.000
64	1.048	1.000
65 and over	1.048	1.000

Federal Age Curve		
Age Band	**Membership Distribution**	**Age Factor**
0-20	10.15%	0.635
21	1.09%	1.000
22	1.09%	1.000
23	1.09%	1.000
24	1.09%	1.000
25	1.09%	1.004
26	1.85%	1.024
27	1.85%	1.048
28	1.85%	1.087
29	1.85%	1.119
30	1.85%	1.135
31	1.85%	1.159
32	1.85%	1.183
33	1.85%	1.198
34	1.85%	1.214
35	1.68%	1.222
36	1.68%	1.230
37	1.68%	1.238
38	1.68%	1.246
39	1.68%	1.262
40	1.68%	1.278
41	1.68%	1.302
42	1.68%	1.325
43	1.68%	1.357
44	1.68%	1.397
45	2.12%	1.444
46	2.12%	1.500
47	2.12%	1.563
48	2.12%	1.635
49	2.12%	1.706
50	2.12%	1.786
51	2.12%	1.865
52	2.12%	1.952
53	2.12%	2.040
54	2.12%	2.135
55	2.98%	2.230
56	2.98%	2.333
57	2.98%	2.437
58	2.98%	2.548
59	2.98%	2.603
60	2.98%	2.714
61	2.98%	2.810
62	2.98%	2.873
63	2.98%	2.952
64	2.98%	3.000
65 and over	0.00%	3.000
Weighted average age factor		1.685

Appendix C
Indiana University Health Plans, Inc.
Rating Factors
(continued)

Geographic Factors		
Rating Area	**Membership Distribution**	**Rating Area Factor**
5	4.5%	0.976
7	30.9%	0.976
8	17.7%	1.006
10	9.0%	1.060
11	2.9%	0.972
13	29.9%	1.010
15	5.1%	0.998
Total	**100.0%**	**1.000**

Plan Value Factors	
Plan Name	**Pricing Value**
IU Health Plans Gold Value	1.191
IU Health Plans Silver HAS	0.992
IU Health Plans Silver Value	1.000
IU Health Plans Silver Enhanced	1.009
IU Health Plans Bronze HAS	0.823
IU Health Plans Bronze Value	0.845
IU Health Plans Bronze Enhanced	0.855

Appendix D
Indiana University Health Plans, Inc.
Plan Adjusted Index Rate Development

Plan Name	Market adjusted index rate (a)	Actuarial value and cost sharing adjustment (b)	Adjustment for distribution and administrative costs (c)	Plan adjusted index rate (d) = (a) + (b) + (c)	Age calibration (e)	Geographic calibration (f)	Calibrated base rate (g) = (d) / [(e) x (f)]
IU Health Plans Gold Value	$ 705.17	$(139.80)	$128.75	$694.12	1.706	1.000	$406.87
IU Health Plans Silver HSA	$ 705.17	$(234.52)	$107.04	$577.69	1.706	1.000	$338.62
IU Health Plans Silver Value	$ 705.17	$(230.51)	$107.95	$582.61	1.706	1.000	$341.51
IU Health Plans Silver Enhanced	$ 705.17	$(226.33)	$108.90	$587.74	1.706	1.000	$344.51
IU Health Plans Bronze HSA	$ 705.17	$(314.62)	$88.73	$479.28	1.706	1.000	$280.94
IU Health Plans Bronze Value	$ 705.17	$(304.07)	$91.13	$492.22	1.706	1.000	$288.52
IU Health Plans Bronze Enhanced	$ 705.17	$(299.15)	$92.24	$498.26	1.706	1.000	$292.06

Appendix E
Indiana University Health Plans, Inc.
Rating Examples

Selected Plan:	IU Health Plans Silver Value
Rating Area:	Rating Area 11

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$341.51	0.972	2.230	1.410	$1,043.86
Spouse	40	Non-Smoker	$341.51	0.972	1.278	1.000	$424.28
Child 1	18	Non-Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 2	15	Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 3	13	Non-Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 4	10	Non-Smoker	$341.51	0.972	0.635	1.000	$0.00
Total Premium							$2,100.57

Selected Plan:	IU Health Plans Gold Value
Rating Area:	Rating Area 7

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$406.87	0.976	2.230	1.410	$1,248.39
Spouse	40	Non-Smoker	$406.87	0.976	1.278	1.000	$507.41
Child 1	18	Non-Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 2	15	Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 3	13	Non-Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 4	10	Non-Smoker	$406.87	0.976	0.635	1.000	$0.00
Total Premium							$2,512.14

Appendix F
Indiana University Health Plans, Inc.
Federal AV Calculator Results

IU Health Plans Gold Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☑		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.80	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.4%
Metal Tier:	Gold

IU Health Plans Silver HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,600.00			
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.0%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.1%
Metal Tier:	Gold

IU Health Plans Silver HSA - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$400.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.1%
Metal Tier:	Platinum

IU Health Plans Silver Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.4%
Metal Tier:	Gold

IU Health Plans Silver Value - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

IU Health Plans Silver Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.7%
Metal Tier:	Gold

IU Health Plans Silver Enhanced - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$150.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$650.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

IU Health Plans Bronze HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.6%
Metal Tier:	Bronze

IU Health Plans Bronze Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	**Drug**	**Combined**	**Medical**	**Drug**	**Combined**
		$6,000.00			
		75.00%			
		$6,350.00			

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$350.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze

IU Health Plans Bronze Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,350.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$275.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☑		$50.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.8%
Metal Tier:	Bronze

Appendix G
Indiana University Health Plans, Inc.
Capital, Surplus, and RBC Information

Annual Statement for the year 2013 of the Indiana University Health Plans, Inc.

ASSETS

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1. Bonds (Schedule D)				
2. Stocks (Schedule D):				
2.1 Preferred stocks				
2.2 Common stocks				
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens				
3.2 Other than first liens				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ encumbrances)				
4.2 Properties held for the production of income (less $ encumbrances)				
4.3 Properties held for sale (less $ encumbrances)				
5. Cash ($ 6,645,144, Schedule E - Part 1), cash equivalents ($, Schedule E - Part 2), and short-term investments ($, Schedule DA)	6,645,144		6,645,144	8,006,798
6. Contract loans (including $ premium notes)				
7. Derivatives (Schedule DB)				
8. Other invested assets (Schedule BA)				
9. Receivables for securities				
10. Securities lending reinvested collateral assets (Schedule DL)				
11. Aggregate write-ins for invested assets				
12. Subtotals, cash and invested assets (Lines 1 to 11)	6,645,144		6,645,144	8,006,798
13. Title plants less $ charged off (for Title insurers only)				
14. Investment income due and accrued	1,068		1,068	2,137
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	231,209	66,791	164,418	201,607
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ earned but unbilled premiums)				
15.3 Accrued retrospective premiums				
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers				
16.2 Funds held by or deposited with reinsured companies				
16.3 Other amounts receivable under reinsurance contracts				
17. Amounts receivable relating to uninsured plans				
18.1 Current federal and foreign income tax recoverable and interest thereon				
18.2 Net deferred tax asset				
19. Guaranty funds receivable or on deposit				
20. Electronic data processing equipment and software				
21. Furniture and equipment, including health care delivery assets ($)				
22. Net adjustment in assets and liabilities due to foreign exchange rates				
23. Receivables from parent, subsidiaries and affiliates	332,038		332,038	714,499
24. Health care ($ 449,493) and other amounts receivable	1,838,476	915,716	922,760	616,348
25. Aggregate write-ins for other than invested assets	1,110,648	156,922	953,726	510,111
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	10,158,583	1,139,429	9,019,154	10,051,500
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28. Total (Lines 26 and 27)	10,158,583	1,139,429	9,019,154	10,051,500

DETAILS OF WRITE-IN LINES				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	NONE			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501. Estimated Medicare Settlement Receivable	953,726		953,726	510,111
2502. Prepaid General and Administrative Expenses	156,922	156,922		
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page				
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	1,110,648	156,922	953,726	510,111

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ 0 reinsurance ceded)				
2.	Accrued medical incentive pool and bonus amounts				
3.	Unpaid claims adjustment expenses				
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Services Act	29,399		29,399	105,075
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	294,066		294,066	229,823
9.	General expenses due or accrued	818,192		818,192	1,431,649
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))				
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others				
13.	Remittances and items not allocated				
14.	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)				
15.	Amounts due to parent, subsidiaries and affiliates				12,550
16.	Derivatives				
17.	Payable for securities				
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified $ (0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans				
23.	Aggregate write-ins for other liabilities (including $ 0 current)	595,407		595,407	871,800
24.	Total liabilities (Lines 1 to 23)	1,737,064		1,737,064	2,650,897
25.	Aggregate write-ins for special surplus funds	XXX	XXX		
26.	Common capital stock	XXX	XXX	1,000	1,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	27,499,000	27,999,000
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	(20,217,910)	(20,599,397)
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX		
	32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	7,282,090	7,400,603
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	9,019,154	10,051,500

	DETAILS OF WRITE-IN LINES				
2301.	Estimated Medicare Settlement Liability	338,139		338,139	667,855
2302.	Other Amounts Payable	257,268		257,268	203,945
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	595,407		595,407	871,800
2501.		XXX	XXX		
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

NONE

NONE

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL - XR025

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		7,282,090	
(2)	Company Action Level=200% of Authorized Control Level	CAL	4,146,860	
(3)	Regulatory Action Level=150% of Authorized Control Level	RAL	3,110,145	
(4)	Authorized Control Level=100% of Authorized Control Level	ACL	2,073,430	
(5)	Mandatory Control Level=70% of Authorized Control Level	MCL	1,451,401	
(6)	Level of Action, if Any		NONE	

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	7,282,090
Authorized Control Level Risk-Based Capital on Line 15 of the Five Year Historical Data Page	2,073,430

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	98,250,957	
(8)	Underwriting Deductions	Page 4, Line 23	97,709,883	
(9)	Combined Ratio	Line (8)/Line(7)	99.400	
(10)	RBC Ratio	Line(1)/Line(4)	351.200	
(11)	Trend Test Result	If Line(10) is between 200% and 300% and Line (9) > 105%, then "Yes", otherwise "No"		No
(12)	Level of Action, if any, including Trend Test		NONE	

IU Health Plans Silver HSA - CSR 73

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,000 per Plan Year
Per Family	$4,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$3,750 per Plan Year
Per Family	$7,500 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	10% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	10% Coinsurance after Deductible
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	10% Coinsurance after Deductible
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order after Deductible
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order after Deductible
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Tier 5 (Specialty)	30% Coinsurance after Deductible
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Value – CSR 73

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,500 per Plan Year
Per Family	$5,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$4,500 per Plan Year
Per Family	$9,000 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit after Deductible and then 10% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$30 Copayment per visit
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	40% Coinsurance after Deductible
Durable Medical Equipment	40% Coinsurance after Deductible
Prosthetics	40% Coinsurance after Deductible
Orthotic Devices	40% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$30 Copayment per visit
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Enhanced – CSR 73

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$2,000 per Plan Year
Per Family	$4,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$4,500 per Plan Year
Per Family	$9,000 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	20% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Dental Services for Accidental Injury	20% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	20% Coinsurance after Deductible
Radiology Services	20% Coinsurance after Deductible
X-ray Services	20% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$250 Copayment per visit and then Deductible and then 20% Coinsurance after Deductible
Urgent Care Center Services	$100 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	20% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	20% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$30 Copayment per visit
Delivery and Inpatient Services	$750 Copayment per admission after Deductible and then 20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$30 Copayment per visit
Specialty Physician	20% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	20% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	20% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver HSA – CSR 87

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$1,000 per Plan Year
Per Family	$2,000 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$1,200 per Plan Year
Per Family	$2,400 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional

information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	10% Coinsurance after Deductible
Inpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	10% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician " or "Primary Care Physician" provisions in this Schedule . For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	10% Coinsurance after Deductible
Urgent Care Center Services	10% Coinsurance after Deductible
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	10% Coinsurance after Deductible
Delivery and Inpatient Services	10% Coinsurance after Deductible
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	10% Coinsurance after Deductible
Specialty Physician	10% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	10% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	10% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	10% Coinsurance after Deductible
Tier 2 (Non-Preferred Generic)	10% Coinsurance after Deductible
Tier 3 (Preferred Brand Name)	10% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	10% Coinsurance after Deductible
Tier 5 (Specialty)	10% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	10% Coinsurance after Deductible
Tier 2 (Non-Preferred Generic)	10% Coinsurance after Deductible
Tier 3 (Preferred Brand Name)	10% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	10% Coinsurance after Deductible
Tier 5 (Specialty)	10% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

IU Health Plans Silver Enhanced – CSR 94

Schedule of Benefits

The Schedule of Benefits is a summary of your Benefits and Cost Sharing. The definitions stated in your Contract apply to this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under this Contract. You are responsible for all expenses for Non-Covered Services.

Subscriber: [Name]

Subscriber ID: [***]

Dependent(s) [List each]
Name: [Name]
Relationship to Subscriber: [relationship]
Date of Birth: [date]

Effective Date: [Date]

Plan Year – [date] through [December 31, 2015]

Deductible: The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible applies to all Covered Services except for Preventive Care, office visits with your Primary Care Physician, Maternity - Prenatal & Postnatal Care, Urgent Care Center Services, and Tier 1 & Tier 2 Prescription Drugs. Copayments do not apply toward the Deductible. Your payments for Non-Covered Services do not apply toward the Deductible.

Deductible	
Per Covered Person	$150 per Plan Year
Per Family	$300 per Plan Year

Out of Pocket Maximum: The Out of Pocket Maximum is the maximum amount that you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum includes the Deductible, Copayments and Coinsurance amounts you pay in a Plan Year for Covered Services. Your payments for Non-Covered Services do not apply toward the Out of Pocket Maximum. Once the Out of Pocket Maximum is satisfied, no additional Copayments or Coinsurance apply for the remainder of the Plan Year.

Out of Pocket Maximum	
Per Covered Person	$650 per Plan Year
Per Family	$1,300 per Plan Year

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that you must pay for Covered Services. Some Covered Services are subject to limitations. Health Care

Services received from Non-Participating Providers are Non-Covered Services unless the Contract specifically provides otherwise. See Article 6 Section B of the Contract for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Benefit	Cost Sharing per Covered Person
Ambulance Services	20% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	20% Coinsurance after Deductible
Inpatient Services	$200 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	$200 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Dental Services for Accidental Injury	20% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.

Benefit	Cost Sharing per Covered Person
Diagnostic Services	
Laboratory Services	20% Coinsurance after Deductible
Radiology Services	20% Coinsurance after Deductible
X-ray Services	20% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost Sharing after Deductible waived if admitted*	$100 Copayment per visit after Deductible and then 20% Coinsurance after Deductible
Urgent Care Center Services	$40 Copayment per visit
Home Care Services	
Home Care Visits - *limited to a maximum of 90 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Covered Person Per Year and 164 visits per Covered Person per lifetime*	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	$200 Copayment per admission after Deductible and then 20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Covered Person Per Year*	20% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Covered Person Per Year*	20% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	$10 Copayment per visit
Delivery and Inpatient Services	$200 Copayment per admission after Deductible and then 20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$10 Copayment per visit
Specialty Physician	20% Coinsurance after Deductible
Preventive Care Services	No charge
Surgical Services	20% Coinsurance after Deductible
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	20% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Manipulation Therapy *limited to a maximum of 12 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Covered Person Per Year*	20% Coinsurance after Deductible

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.

Benefit	Cost Sharing per Covered Person
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not applicable
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services - Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount

Benefit	Cost Sharing per Covered Person
Transportation and Lodging	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply*	
Tier 1 (Preferred Generic and Preventive)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic and Preventive)	$15 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$45 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	20% Coinsurance after Deductible
Tier 4 (Non-Preferred Brand Name)	30% Coinsurance after Deductible
Tier 5 (Specialty)	30% Coinsurance after Deductible

Benefit	Cost Sharing per Covered Person
Pediatric Vision (persons under age 19)	
Eye exam - *limited to 1 exam per Covered Person per Year*	No charge
Eyeglass Lenses - *limited to 1 set of lenses per Covered Person per Year*	No charge
Eyeglass Frames - *limited to 1 set of frames per Covered Person Per Year*	No charge for Provider Designated Frames
Contact Lenses – *includes materials only, covered once per Person Per Year in lieu of eyeglasses*	No charge for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses

[INSERT LOGO]

Individual/Family/Child-Only Contract Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with [Indiana University Health Plans], premium payment is required before the requested effective date. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call [1 800-XXX-XXXX]. If you have questions about a previously submitted application, please call [1 800-XXX-XXXX].

DISCLAIMER: The Affordable Care Act includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments of Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. **Please be advised that this Policy does not qualify for these affordability programs because it is not issued through the Indiana Marketplace.**

Section A – Coverage Information

Coverage Type (select one):

☐ Individual/Family ☐ Child-Only

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No. _____

Open Enrollment:

During the annual Open Enrollment period, you may apply for coverage, or change plans. The earliest Effective Date for the Initial Open Enrollment is [January 1, 2015]. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if [Indiana University Health Plans, Inc.] receives the application and initial premium payment between the 1st and 15th of the month. If [Indiana University Health Plans, Inc.] received the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st).

Applications must be received during the Open Enrollment period. An applicant may enroll outside of the Open Enrollment period only if he/she experiences a Special Enrollment triggering event provided below. Notice of a triggering event must be received by [Indiana University Health Plans, Inc.] within [60] days of the triggering event.

Special Enrollment Triggering Events:

Please check the triggering event:

☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;

☐ Loss of Minimum Essential Coverage due to dissolution of marriage;

☐ Marriage, birth, adoption or placement for adoption or appointment of guardianship;

☐ Violation of a Qualified Health Plan of a material contract provision;

☐ Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and result of an error, misrepresentation, or inaction of the Indiana Marketplace or the US Department of Health and Human Services;

☐ Newly ineligible for advance payments of premium tax credits or cost-sharing reductions.

☐ Relocation to a new service area;

☐ Determination that enrollment or non-enrollment in a Qualified Health Plan or an incorrect determination of ineligibility of advance payments of premium tax credits or cost-sharing reductions was the result of misconduct by a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities.

Please provide the date of the triggering event: _____

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)			
City	**State**	**ZIP**	**County**

Billing Address (street and P.O. Box if different from above)		
City	**State**	**ZIP**

Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth / /

Primary Phone Number ( )	Secondary Phone Number ( )	E-mail*

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this application.*

Section C – Spouse to be Covered Information (N/A if applying for Child-Only coverage)

Last Name	First Name	MI	Relationship ☐ Spouse
Social Security Number*	Sex ☐ M ☐ F	Date of Birth / /	

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this application.*

Section D – Child Dependents to be Covered Information
(All fields must be completed. Attach a separate sheet if necessary).

Dependent information must be completed for all child dependents (if any) to be covered under this policy.

For family coverage, an eligible child dependent includes your child or your spouse's child, including any of the following until the child attains the age of 26: your natural child, stepchild, legally adopted child, child placed for the purpose of adoption, or child placed under legal guardianship or legal custody.

For child-only coverage, an eligible child dependent includes your child or your spouse's child, including any of the following until the child attains the age of 21: your natural child, stepchild, legally adopted child, child placed for the purpose of adoption, or child placed under legal guardianship or legal custody.

(Please list all dependents beginning with the eldest.)

Last Name	**First Name**	**MI**	**Sex**	**Date of Birth mm/dd/yyyy**	**Social Security Number***	**Relationship to Applicant**
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other: _____
			M F ☐ ☐			☐ Child ☐ Other: _____
			M F ☐ ☐			☐ Child ☐ Other: _____
			M F ☐ ☐			☐ Child ☐ Other: _____

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this application.*

Are all applicants listed on this application residents of Indiana? ☐ Yes ☐ No

If **YES**, please list the county of residence for each applicant:_____

_____

If **NO**, please list each applicant that is not a resident of Indiana:_____

_____

Has any applicant used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No

If **YES**, please list each applicant that has used tobacco products 4 or more times per week, on average, in the last 6 months:_____

_____

Section E – Medical Coverage

Select ONE Plan.

[☐ IU Health Plans Bronze Value]

[☐ IU Health Plans Bronze Enhanced]

[☐ IU Health Plans Silver Value]

[☐ IU Health Plans Silver Enhanced]

[☐ IU Health Plans Silver Value 87]

[☐ IU Health Plans Silver Enhanced 87]

[☐ IU Health Plans Silver Value 73]

[☐ IU Health Plans Silver Enhanced 73]

[☐ IU Health Plans Silver Value 94]

[☐ IU Health Plans Silver Enhanced 94]

[☐ **IU Health Plans Gold Value]**

[☐ IU Health Bronze HSA]

[☐ IU Health Plans Silver HSA]

[☐ IU Health Plans Silver HAS 87]

[☐ IU Health Plans Silver HSA 73]

[☐ IU Health Plans Silver HSA 94]

Health Savings Account Election:

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to [Indiana University Health Plans, Inc.'s] banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to [Indiana University Health Plans, Inc.'s] banking partner.

Section F – Pediatric Dental Coverage Certification

Child dependents age 19 and under are required to enroll in pediatric dental coverage that is certified by the Indiana

Marketplace. [Indiana University Health Plans, Inc.] does not offer this mandated pediatric dental coverage.

☐ **YES**, I will enroll my child dependent(s) age 19 and under in a standalone dental plan that meets the mandated pediatric dental coverage requirement.

☐ **NO,** I will not enroll my child dependent(s) age 19 and under in a standalone dental plan that meets the mandated pediatric dental coverage requirement.

Section G – Other Health Coverage For Purposes of Coordination of Benefits Under the Policy

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, please list all applicants that are currently eligible for Medicare: _____

_____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No

If **YES**, please list all applicants current receiving such benefits and the reason they are receiving such benefits:

_____

_____

_____

Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____

Do you, or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If YES, please provide the following information:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for [Indiana University Health Plans, Inc.] coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although [Indiana University Health Plans, Inc.'s] requires payment with my application, sending my initial premium with this application, and the receipt of my payment by [Indiana University Health Plans, Inc.], does not mean that coverage has been approved. I may not assign any payment under my [Indiana University Health Plans, Inc.]program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, [Indiana University Health Plans, Inc.] reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify [Indiana University Health Plans, Inc.] of any change that would make me or any dependent ineligible for coverage.
- [I understand [Indiana University Health Plans, Inc.] may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any [Indiana University Health Plans, Inc.] automatic debit process and will only occur each time I send a check to [Indiana University Health Plans, Inc.]. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.]
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between [Indiana University Health Plans, Inc.] and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- ☐ By checking this box, I authorize and expressly consent that [Indiana University Health Plans, Inc.] and its affiliated companies may send e-mail communications instead of sending communications by mail, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting [Indiana University Health Plans, Inc.] customer service or online at [INSERT WEBSITE].
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by [Indiana University Health Plans, Inc.] in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

REMAINDER OF PAGE LEFT BLANK

SIGNATURE PAGES FOLLOW

I give this authorization for and on behalf of any eligible dependents and myself if covered by [Indiana University Health Plans, Inc.]. I am acting as their agent and representative.

This application shall be altered solely by the applicant or with his or her written consent.

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your [Indiana University Health Plans, Inc.] appointed agent/broker:

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature **X**				Date
Agent/Broker Name (please print)		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.		
Agent/Broker ID/TIN	Agency ID/Parent TIN	City	State	ZIP
Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail		

Authorization for Use of Protected Health Information

By signing below: I authorize [Indiana University Health Plans, Inc.], or an agent/broker, subsidiary or affiliate that has a business associate contract with [Indiana University Health Plans, Inc.], to obtain any medical records or other health history information concerning me and any family member listed on my application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations.

This authorization is subject to revocation at any time by written notice to [Indiana University Health Plans, Inc.] except to the extent that [Indiana University Health Plans, Inc.] has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

Unless previously revoked, this authorization is valid for 24 months from the date of signature.

Printed name of Applicant/Member **X**	Signature of Applicant/Member or his/her Legal Representative **X**	Date
Printed name of Spouse or Dependent Child* age 18 or over listed on this application **X**	Signature of Spouse or Dependent Child* or his/her Legal Representative **X**	Date
Printed name of Dependent Child* age 18 or over listed on this application **X**	Signature of Dependent Child* or his/her Legal Representative **X**	Date

**If listed on your application or change form, your spouse and each dependent child age 18 or over must sign above.*
If a legal representative signs on behalf of the applicant or spouse, a copy of the legal representative's authority must be attached to the application.
A photocopy of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.

Actuarial Memorandum

Indiana University Health Plans, Inc.

Individual Health Rate Filing

Effective January 1, 2015 through December 31, 2015

Form: 13164.1-Indiv-Policy-Adult (01/2015)

13164.1-Indiv-Policy-Child (01/2015)

Submitted: May 9, 2014

TABLE OF CONTENTS

1) General Information 3
2) Proposed Rate Increase(s) 4
3) Experience Period Premium and Claims 4
4) Benefit Categories 5
5) Projection Factors 5
6) Credibility Manual Rate Development 5
7) Credibility of Experience 7
8) Paid to Allowed Ratio 7
9) Risk Adjustment and Reinsurance 8
10) Non-Benefit Expenses and Profit & Risk 8
11) Projected Loss Ratio 9
12) Single Risk Pool 10
13) Index Rate 10
14) Market Adjusted Index Rate 10
15) Plan Adjusted Index Rates 11
16) Calibration 12
17) Consumer Adjusted Premium Rate Development 12
18) AV Metal Values 13
19) AV Pricing Values 13
20) Membership Projections 13
21) Terminated Products 14
22) Plan Type 14
23) Warning Alerts 14
24) Company Financial Position 14
25) Reliance 14
26) Actuarial Certification 15

1) General Information

Overview

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template (URRT), which supports compliance with the market rating rules and reasonableness of applicable rate increases.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with State of Indiana statutes and provisions of the Affordable Care Act (ACA). This memorandum documents the development of the Individual rates for Indiana University Health Plans, Inc. (IUHP). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This information may not be appropriate for other purposes.

This information is intended for use by the State of Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of IUHP's Individual rate filing. However, we recognize that this certification may become a public document. PwC makes no representations or warranties regarding the contents of this memorandum to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for IUHP by PwC that would result in the creation of any duty or liability under any theory of law by PwC or its employees to third parties.

These results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

Company Identifying Information

- Company Legal Name: Indiana University Health Plans, Inc.
- State: The State of Indiana has regulatory authority over these policies
- HIOS Issuer ID: 33380
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: Eric Neuville, Vice President Product Development and Innovation
- Primary Contact Telephone Number: (317) 963-1835
- Primary Contact Email Address: eneuville@iuhealth.org

Certifying Actuary Contact Information

- Primary Contact Name: Robert Macagnano, PwC
- Primary Contact Telephone Number: (973) 236-4082
- Primary Contact Email Address: robert.macagnano@us.pwc.com

Benefit Summary

IUHP will be offering three Bronze, three Silver, and one Gold HMO products. A summary of the major provisions of each plan are provided in Appendix A.

Premium Guarantee Provision

Premiums are guaranteed not to change through December 31, 2015.

Renewability

The policy is renewable by paying the applicable renewal premiums unless the policyholder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability

The rates will apply to new business. Subsequent renewal business will be subject to rates filed for our 2016 rate development.

Premium Modalization

Premiums will be collected only on a monthly basis.

Trend Assumption

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2) Proposed Rate Increase(s)

This is a new filing therefore no rate increase assumption is included in this filing. Subsequent rate increases beginning with effective dates of January 1, 2016 will be filed in the future.

3) Experience Period Premium and Claims

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

4) Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.

Capitation: Includes capitated services for pediatric vision benefits.

Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

5) Projection Factors

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6) Credibility Manual Rate Development

The PwC Rating Model was used as the basis to develop the manual rates. Our model was developed using two primary sources:

- Commercial Truven Health MarketScan® Research Databases for U.S. members and providers. The database contains full enrollment and claims information with standard medical coding which allows for cost and utilization information by service category (inpatient, outpatient hospital, hospice, home health, professional, prescription drugs, etc.). The database consists of the experience from 53 million Commercial eligible participants. The data can be extracted down to the member's state and MSA level. For the Indiana Commercial market, there were approximately 1.5 million exposed life years' worth of data crossing all ages, genders and employment statuses (active, COBRA, disabled and retired). Nationwide, the databases have over 100 unique data contributors so it is not skewed to any one payer.
- OptumInsight (Optum) Comprehensive Pricing Model® provides benchmark data and pricing capabilities for Commercial health plans. It factors in health plan features such as

deductibles, copays, out-of-pocket maximums, covered services, etc. The model uses normative data and benefit details to arrive at an allowed cost per member per month. The normative benchmarking utilization metrics within the model are developed from Optum's database of Commercial (under 65) health plan experience of approximately 20 million life years. The model experience was adjusted to reflect the Indiana marketplace.

Since both the Truven and Optum data sources represent fully-completed calendar year 2012 claims, allowed costs were trended to the midpoint of calendar year 2015 using an annual trend rate of 7.4%.

The allowed costs component of the manual rates was increased by 2% to account for expected changes in covered benefits due to the Essential Health Benefits (EHB) requirements. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- State mandated benefits included in the EHB that previously only applied to group coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

The manual rates were increased by 15% to reflect the entrance of approximately 7,000 Medicaid Spend-Down beneficiaries into the Indiana Health Insurance Exchange. This adjustment was based on the assumption that IUHP's penetration of the Medicaid Spend-Down population would be similar to their assumed penetration of the general population. Expenditure information for the Medicaid Spend-Down population was provided by the Indiana Family and Social Services Administration and contained in the April 21, 2014 study "Spend Down Exchange Impact: Transition to the Indiana Health Insurance Exchange" performed by Milliman, Inc. In addition, preliminary estimates provided by the Indiana Department of Insurance (IDOI) during their May 2, 2014 Weekly ACA Rate & Form Filing Call Session indicated that the inclusion of this population would increase premiums by 5% - 15%. We have been informed by the IDOI that additional information pertaining to this population will be made available. We reserve the right to revise our filing to reflect this data subsequent to this filing.

There will also be new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services. Pent up demand has been shown to increase costs in the first year of enrollment for those previously uninsured. Based on analysis of programs serving a similar population, it appears that the claims are higher in the first six to 12 months that an individual is newly insured. After this initial period, the claims experience tends to revert to the average level for the market. The total effect is uncertain and may be offset by some new enrollees having reduced utilization as they may not fully

understand new or increased coverage. Therefore, we have included an adjustment within our manual rate development for pent up demand of 5.0%.

The following adjustments were made to calibrate the pricing model to the expected population:

- Rating region
- Expected demographics
- Expected morbidity
- Contractual Agreements with healthcare providers
- Expected utilization management savings
- Benefit plan designs

Some benefits will be reimbursed under a capitation arrangement. The provider reimbursement adjustment to the pricing model was developed to account for the cost of capitated services.

The manual rates were also adjusted upward by a factor of 1.005 to account for the likelihood that some enrollees may not pay their premiums due during the first month of the 90-day grace period. This was calculated assuming a 15% rate of non-payment on one-twelfth of the annual premium due for 80% of the Individual population (those eligible for Advance Payments of a Premium Tax Credit). The amount of premium at risk is only on the portion that IUHP does not receive via direct subsidy, estimated to be 50% (0.15 x 1/12 x 0.80 x 0.50 = 0.005). The 15% represents our assumption regarding the small portion of enrollees that we believe will knowingly take advantage of the grace period provision. The 80% represents the portion of enrollees in the 2015 Individual marketplace that we assume will be eligible for premium subsidies based on income level. On May 1, 2014 the Department of Health and Human Services reported that as of April 19, 2014, 89% of those enrolled in the Indiana exchange were eligible for federal assistance. Our assumption is that this percentage will decrease during 2015.

7) Credibility of Experience

IUHP has not previously operated in the individual market. As a result the “Experience Period” section of Worksheet 1 of the URRT has not been populated. Similarly, the projection factors (cells J24:M29 on Worksheet 1) have also been left blank. The service category PMPMs shown in the “Credibility Manual” section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

8) Paid to Allowed Ratio

The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT calculates the PMPM costs on both an allowed and paid basis. The “Paid to Allowed Average Factor in Projection Period” shown on Worksheet 1, Section III of the URRT is developed by membership-weighted EHB paid claims divided by membership-weighted EHB allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

9) Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, IUHP is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value. Therefore, no risk adjustment PMPM payment is assumed for 2015.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only)

The Federal transitional reinsurance program is a temporary risk mitigation program expected to reduce costs for insurance issuers. The 2015 reinsurance program has an attachment point of $70,000 and a maximum coverage limit of $250,000 per member. The Department of Health and Human Services will reimburse insurance issuers 50% of paid costs between the attachment point and maximum coverage limit.

Allowed claims were reduced by 7.0% to account for the anticipated 2015 reimbursements from this temporary program. This estimate was developed using projected paid claims, a claims probability distribution calibrated to the expected average claim levels for the 2015 Individual market, and the federal program guidelines summarized above. The expected reinsurance reimbursements of $51.43 PMPM are allocated proportionally by plan based on allowed claims. Applying the 2015 transitional reinsurance charge of $3.67 PMPM yields a net reinsurance cost of $47.76 PMPM.

Projected Net Cost of Private Reinsurance

The projected net cost of private reinsurance for 2015 is $0.00 PMPM since IUHP does not intend to purchase private reinsurance.

10) Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

IUHP developed their expected administrative expenses based on: a) current administrative expenses for their Medicare line of business adjusting for any expected differences for their Commercial products, and b) a review of 2014 Rate Filings for Individual Exchange products. A summary of IUHP's assumptions is as follows:

- Administrative expenses (excluding Sales and Marketing expenses): 10.50% of premium
- Sales and Marketing expenses (including commissions): 3.70% of premium

These administrative expenses are allocated proportionally by plan.

Quality Improvement Expenses

At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. Therefore, no explicit Quality Improvement expenses were assumed.

Profit & Risk Margin

The proposed rates reflect a profit & risk margin of 3.0% of premium. This load was applied to all products and plans.

Taxes and Fees

A summary of the assumed taxes and fees are summarized below:

PMPM Basis

- Transitional reinsurance charge: $3.67 PMPM ($44.00 per member per year)
- Risk adjustment user fee: $0.08 PMPM
- PCORI fee: $0.17 PMPM ($2.00 per member per year)

Percentage of Premium Basis

- Health insurance exchange fee: 3.15% of premium reflecting IUHP's assumption that 90% of their expected 2015 business will be sold through the exchange
- ACA issuer fee: IUHP will not be subject to this fee for 2015
- Premium tax: 1.30% of premium

11) Projected Loss Ratio

The overall projected medical loss ratio for 2015 is 82.5%. This calculation excludes regulatory fees and taxes. At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. As a result, we have not included an adjustment in the MLR calculation for these expenses. It is IUHP's intent to identify their Quality Improvement expenses for purposes of submitting their MLR-related filings and calculating related rebates, if any. The table below shows the calculation.

a)	Incurred Claims Net of Cost Sharing	$501.10
b)	Transitional Reinsurance Reimbursement	($51.43)
c)	Reinsurance Charge	$3.67
d)	Quality Improvement Expenses	$0.00
e)	Worksheet 1 Projected Incurred Claims (a+b+c+d)	$453.34
f)	Administrative Expenses	$82.21
g)	Profit & Risk Margin	$17.37
h)	Regulatory Taxes and Fees (excluding reinsurance charge)	$26.01
i)	Gross Premium (e+f+g+h)	$578.92
j)	Medical Loss Ratio (e/(i-c-h))	82.5%

12) Single Risk Pool

IUHP has not previously operated in the Individual market and thus does not have any claims experience to develop its own Single Risk Pool. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

13) Index Rate

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the Index Rate for the Experience Period has been left blank.

The Index Rate of $734.69 for the 2015 Projection Period represents the overall projected allowed costs PMPM for providing Essential Health Benefits for the Single Risk Pool. Since this is a new product, the index rate was developed based on a manual rate as described above in the Credibility Manual Rate Development section. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

14) Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic characteristics of the Single Risk Pool. In other words, the Market Adjusted Index Rate is not calibrated.

The development of the Federal reinsurance program and risk adjustments was described above in the Risk Adjustment and Reinsurance section. The development of the Exchange user fee adjustment was described above in the Non-Benefit Expenses and Profit & Risk section.

Index Rate	$734.69
Reinsurance Reimbursements (7.0% of Allowed Claims – Index Rate)	($51.43)
Reinsurance Premiums	$ 3.67
Risk Adjustment	$ 0.00
Exchange user fee (3.15% of average premium for Single Risk Pool)	$ 18.24
Market Adjusted Index Rate	$705.17

15) Plan Adjusted Index Rates

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the Part I Unified Rate Review Template in 2015. These Plan Adjusted Index Rates have been adjusted to remove the portion of the allowed cost that is expected to be recouped through the tobacco surcharge. The average tobacco surcharge for the Single Risk Pool is approximately 1.4%.

The Plan Adjusted Index Rates reflect the average demographic characteristics of the Single Risk Pool. In other words, the Plan Adjusted Index Rates are not calibrated.

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

- Actuarial value and cost sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)
- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

Only the actuarial value and cost sharing & distribution and administrative costs adjustments were applicable to IUHP.

Actuarial Value and Cost Sharing Adjustment

This adjustment includes three components:

- Removal of tobacco surcharge - the average tobacco surcharge factor was applied to the average allowed costs for the Single Risk Pool
- Benefit richness utilization adjustments - The reference plan underlying our pricing was a Silver plan. Benefit richness utilization adjustments were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge). These adjustments were based on the values published in the Federal Register payment notice, normalized to the Silver plan level. The adjustments for each metallic tier are as follows:
    - Bronze = 1.00 / 1.03 = 0.9709
    - Silver = 1.00 / 1.00 = 1.0000
    - Gold = 1.08 / 1.03 = 1.0485
- Cost Sharing - The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT was used to calculate the cost sharing percentage for each plan. These cost sharing percentages were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge and applying the benefit richness utilization adjustments). The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

Adjustment for Distribution and Administrative Costs

Fixed and variable costs as described in the Non-Benefit Expenses and Profit & Risk section were included in this adjustment as follows:

- Fixed costs: Risk adjustment user and PCORI fees
- Variable costs (% of premium): Administrative expenses, sales & marketing expenses, profit & risk margin, and premium taxes. The percentages applied did not vary by plan.

Appendix D shows the development of the Plan Adjusted Index Rates.

16) Calibration

The Plan Adjusted Index Rates (which are based on the Single Risk Pool) were calibrated to apply the allowable rating factors in order to calculate Consumer Adjusted Premium Rates. The calibration by age and geography is described below.

Age Curve Calibration

The methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology and conforms with the rating rules specified in 45 CFR 147.102.

The expected membership distribution by age band was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. A uniform distribution within each age band was also assumed. A weighted average age factor of 1.685 for the Single Risk Pool was also determined by applying the membership distribution to the Federal age curve. This represents a rounded weighted average age of 49. Appendix C shows the development of the weighted average age factor.

The Plan Index Rates were calibrated by dividing by 1.706 which represents the standard age factor of the rounded weighted average age of 49. This calibration factor does not vary by plan.

Geographic Factor Calibration

A geographic factor calibration was not required since the weighted average of the geographic factors equals 1.0. The Geographic (rating area) factors were developed based upon the network characteristics for unit cost and utilization management in each of the established rating areas. Based upon the expected distribution of enrolment by area, the area factors reflect the Single Risk Pool results consistent with the URRT.

Appendix D shows how the calibration adjustments were applied to the Plan Adjusted Index Rates.

17) Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate

is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography if necessary, and applying the rating factors specified by 45 CFR Part 147, §147.102. The following adjustments are allowable under this rule:

- Whether the plan coverage covers an individual or family (issuers must cover any eligible individual and/or eligible family that requests coverage per the guaranteed issue requirement of the ACA); this is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor
- Rating area
- Age – reflecting the applicable age curve
- Tobacco status

The rating factors (shown in Appendix C) are applied at an individual level and added together to calculate the family rate, with the exception that no more than 3 covered children under the age of 21 are charged a rate. Adjustment for family size is in accordance with Federal rules. The examples in Appendix E show how the rating factors are applied to the calibrated Plan Adjusted Index Rate.

18) AV Metal Values

The Federal AV calculator was used without any modifications to generate the Metal Values included in Worksheet 2 of the URRT. Please refer to Appendix F for screen shots showing the AV calculations for each plan.

19) AV Pricing Values

The Silver Value plan was selected as the fixed reference plan and serves as the basis for the AV Pricing Values. Please refer to Appendix C for the AV Pricing Values for each plan which are also included in Worksheet 2, Section I of the URRT. The AV Pricing Value for each plan reflects the relative impact of the plan's cost-sharing amounts, expected impact on enrollee utilization due to benefit richness (excluding impact of morbidity), expected additional cost of non-EHB, and administrative expenses (excluding health insurance exchange user fees).

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the PwC Rating Model as described above in the Credibility Manual Rate Development section was used to develop the benefit relativities for the AV Pricing Values.

20) Membership Projections

Membership projections were based on market penetration assumptions provided by IUHP. These assumptions reflected the uninsured and individual market populations by county, income level, and other characteristics such as the presence of IUHP facilities and delivery system within a given county.

The expected membership distribution by age band and metallic tier was based upon the Indiana

Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. For the Silver plans, the portion of the projected enrollment that will be eligible for CSR subsidies at each subsidy level was based on the income level detail in the market penetration analysis provided by IUHP.

Summaries of the projected membership by age, metallic tier, and CSR subsidy level are shown in Appendix B.

21) Terminated Products

Not applicable. IUHP does not currently have Individual plans in the State of Indiana.

22) Plan Type

All plans listed types in Worksheet 2, Section I of the URRT correctly describe IUHP's plans as "HMO".

23) Warning Alerts

Two warnings were generated in the URRT, both of which were due to adjustments to the allowed costs between Worksheet 1 and Worksheet 2. The first adjustment was the removal of the impact of the tobacco surcharge of 1.4% as required in the reporting of the Plan Adjusted Index Rates and related items in Worksheet 2. This resulted in a decrease in allowed claims of $xxxxx PMPM between Worksheets 1 and 2. The second adjustment was the application of the induced utilization factors in the development of the Plan Adjusted Index Rate for each plan. When aggregated, the impact of induced utilization was a reduction of xxxx% or $ yyyyy PMPM.

24) Company Financial Position

Please see Appendix G for information regarding the capital and surplus position of IUHP.

25) Reliance

In the preparation of this filing, I have relied upon data provided by Eric Neuville (Vice President Product Development and Innovation), Connie Brown (CFO and COO), and IUHP management. I did not audit this data but did review it for reasonableness. This information includes but is not limited to the following items:

- Administrative expense projections
- Provider reimbursement levels (including capitation arrangements)
- Projected enrollment
- Projected pharmacy discounts, unit costs and rebates
- Financial statement information

26) Actuarial Certification

I, Robert Macagnano, FSA, MAAA, am affiliated with PricewaterhouseCoopers LLP (PwC). I am a Member of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinion contained herein. This filing is prepared on behalf of Indiana University Health Plans, Inc. (the "Company").

I certify that this filing has been prepared in accordance with the following Actuarial Standards of Practice (ASOP) including:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications

I certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

I certify that the Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

On/Off Exchange Attestation

I certify that a single set of premium rates was submitted with this filing which is applicable for all plans offered both on and off the Exchange, and that this assures the same premium rate will be charged without regard to whether the plan is offered through the Exchange or whether the plan is offered directly from the Company or through an agent.

QHP Off Exchange Premium Tax Credit (PTC) Attestation

To notify consumers that coverage purchased outside of the Exchange is not eligible for premium tax credit assistance, the Company will include the following language in their marketing materials:

"DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace."

This disclaimer is located on page 1 of the Company's policy form.

The Part I Unified Rate Review Template does not demonstrate the process used by the Company to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Respectfully submitted,



Robert Macagnano, FSA, MAAA
Director
(973) 236-4082
Robert.Macagnano@us.pwc.com

Appendix A
Indiana University Health Plans, Inc.
Plan Design Summaries

Plan Name	Deductible	OOP Max	Coinsurance	PCP Visit	Specialist Visit	ER Visit	Inpatient Stay	Rx - Retail	Rx - Mail Order
IU Health Plans Gold Value	$750/$1,500	$6,000/$12,000	20% after deductible	$20 copay	$50 copay before deductible and 20% after deductible	$200 copay then deductible and 20% coinsurance	$500 copay then deductible and 20% coinsurance	$8/$20/20%/30%/30% (coinsurance applies after deductible)	$24/$60/20%/30%/30% (coinsurance applies after deductible)
IU Health Plans Silver HSA	$2,750/$5,500	$3,600/$7,200	10% after deductible	10% after deductible	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% after deductible	$15/$45/25%/35%/35% after deductible
IU Health Plans Silver Value	$2,500/$5,000	$6,350/$12,700	10% after deductible	$40 copay	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Silver Enhanced	$2,000/$4,000	$5,750/$11,500	20% after deductible	$30 copay	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Bronze HSA	$4,500/$9,000	$6,350/$12,700	20% after deductible	20% after deductible	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$10/$25/30%/40%/40% after deductible	$30/$75/30%/40%/40% after deductible
IU Health Plans Bronze Value	$6,000/$12,000	$6,350/$12,700	25% after deductible	$40 copay	25% after deductible	$350 copay then deductible and 25% coinsurance	$1,500 copay then deductible and 25% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)
IU Health Plans Bronze Enhanced	$5,000/$10,000	$6,350/$12,700	40% after deductible	$50 copay before deductible and then 40% after deductible	40% after deductible	$275 copay then deductible and 40% coinsurance	$750 copay then deductible and 40% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area

Member Distribution by Age	
Age Band	**Membership Distribution**
0-20	10.15%
21	1.09%
22	1.09%
23	1.09%
24	1.09%
25	1.09%
26	1.85%
27	1.85%
28	1.85%
29	1.85%
30	1.85%
31	1.85%
32	1.85%
33	1.85%
34	1.85%
35	1.68%
36	1.68%
37	1.68%
38	1.68%
39	1.68%
40	1.68%
41	1.68%
42	1.68%
43	1.68%
44	1.68%
45	2.12%
46	2.12%
47	2.12%
48	2.12%
49	2.12%
50	2.12%
51	2.12%
52	2.12%
53	2.12%
54	2.12%
55	2.98%
56	2.98%
57	2.98%
58	2.98%
59	2.98%
60	2.98%
61	2.98%
62	2.98%
63	2.98%
64	2.98%
65 and over	0.00%

Membership Distribution by Rating Area	
Rating Area	**Membership Distribution**
5	4.5%
7	30.9%
8	17.7%
10	9.0%
11	2.9%
13	29.9%
15	5.1%
Total	**100.0%**

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area
(continued)

		Silver					
Plan Name	**Gold**	**70**	**CSR 73**	**CSR 87**	**CSR 94**	**Bronze**	**Total**
IU Health Plans Gold Value	73						73
IU Health Plans Silver HSA		28	-	-	-		28
IU Health Plans Silver Value		168	152	284	69		673
IU Health Plans Silver Enhanced		84	76	142	35		337
IU Health Plans Bronze HSA						35	35
IU Health Plans Bronze Value						210	210
IU Health Plans Bronze Enhanced						105	105
Total	73	280	229	426	104	351	1,462

Appendix C
Indiana University Health Plans, Inc.
Rating Factors

Age-Based Tobacco Factors		
Age	**Smoker**	**Non-smoker**
0-20	1.000	1.000
21	1.050	1.000
22	1.050	1.000
23	1.050	1.000
24	1.050	1.000
25	1.050	1.000
26	1.050	1.000
27	1.050	1.000
28	1.050	1.000
29	1.050	1.000
30	1.050	1.000
31	1.070	1.000
32	1.090	1.000
33	1.110	1.000
34	1.130	1.000
35	1.150	1.000
36	1.170	1.000
37	1.190	1.000
38	1.210	1.000
39	1.230	1.000
40	1.250	1.000
41	1.270	1.000
42	1.290	1.000
43	1.310	1.000
44	1.330	1.000
45	1.350	1.000
46	1.370	1.000
47	1.390	1.000
48	1.410	1.000
49	1.430	1.000
50	1.450	1.000
51	1.470	1.000
52	1.490	1.000
53	1.490	1.000
54	1.473	1.000
55	1.410	1.000
56	1.348	1.000
57	1.290	1.000
58	1.234	1.000
59	1.208	1.000
60	1.158	1.000
61	1.118	1.000
62	1.094	1.000
63	1.065	1.000
64	1.048	1.000
65 and over	1.048	1.000

Federal Age Curve		
Age Band	**Membership Distribution**	**Age Factor**
0-20	10.15%	0.635
21	1.09%	1.000
22	1.09%	1.000
23	1.09%	1.000
24	1.09%	1.000
25	1.09%	1.004
26	1.85%	1.024
27	1.85%	1.048
28	1.85%	1.087
29	1.85%	1.119
30	1.85%	1.135
31	1.85%	1.159
32	1.85%	1.183
33	1.85%	1.198
34	1.85%	1.214
35	1.68%	1.222
36	1.68%	1.230
37	1.68%	1.238
38	1.68%	1.246
39	1.68%	1.262
40	1.68%	1.278
41	1.68%	1.302
42	1.68%	1.325
43	1.68%	1.357
44	1.68%	1.397
45	2.12%	1.444
46	2.12%	1.500
47	2.12%	1.563
48	2.12%	1.635
49	2.12%	1.706
50	2.12%	1.786
51	2.12%	1.865
52	2.12%	1.952
53	2.12%	2.040
54	2.12%	2.135
55	2.98%	2.230
56	2.98%	2.333
57	2.98%	2.437
58	2.98%	2.548
59	2.98%	2.603
60	2.98%	2.714
61	2.98%	2.810
62	2.98%	2.873
63	2.98%	2.952
64	2.98%	3.000
65 and over	0.00%	3.000
Weighted average age factor		1.685

Appendix C
Indiana University Health Plans, Inc.
Rating Factors
(continued)

Geographic Factors		
Rating Area	**Membership Distribution**	**Rating Area Factor**
5	4.5%	0.976
7	30.9%	0.976
8	17.7%	1.006
10	9.0%	1.060
11	2.9%	0.972
13	29.9%	1.010
15	5.1%	0.998
Total	**100.0%**	**1.000**

Plan Value Factors	
Plan Name	**Pricing Value**
IU Health Plans Gold Value	1.191
IU Health Plans Silver HAS	0.992
IU Health Plans Silver Value	1.000
IU Health Plans Silver Enhanced	1.009
IU Health Plans Bronze HAS	0.823
IU Health Plans Bronze Value	0.845
IU Health Plans Bronze Enhanced	0.855

Appendix D
Indiana University Health Plans, Inc.
Plan Adjusted Index Rate Development

Plan Name	Market adjusted index rate (a)	Actuarial value and cost sharing adjustment (b)	Adjustment for distribution and administrative costs (c)	Plan adjusted index rate (d) = (a) + (b) + (c)	Age calibration (e)	Geographic calibration (f)	Calibrated base rate (g) = (d) / [(e) x (f)]
IU Health Plans Gold Value	$ 705.17	$(139.80)	$128.75	$694.12	1.706	1.000	$406.87
IU Health Plans Silver HSA	$ 705.17	$(234.52)	$107.04	$577.69	1.706	1.000	$338.62
IU Health Plans Silver Value	$ 705.17	$(230.51)	$107.95	$582.61	1.706	1.000	$341.51
IU Health Plans Silver Enhanced	$ 705.17	$(226.33)	$108.90	$587.74	1.706	1.000	$344.51
IU Health Plans Bronze HSA	$ 705.17	$(314.62)	$88.73	$479.28	1.706	1.000	$280.94
IU Health Plans Bronze Value	$ 705.17	$(304.07)	$91.13	$492.22	1.706	1.000	$288.52
IU Health Plans Bronze Enhanced	$ 705.17	$(299.15)	$92.24	$498.26	1.706	1.000	$292.06

Appendix E
Indiana University Health Plans, Inc.
Rating Examples

Selected Plan:	IU Health Plans Silver Value
Rating Area:	Rating Area 11

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$341.51	0.972	2.230	1.410	$1,043.86
Spouse	40	Non-Smoker	$341.51	0.972	1.278	1.000	$424.28
Child 1	18	Non-Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 2	15	Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 3	13	Non-Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 4	10	Non-Smoker	$341.51	0.972	0.635	1.000	$0.00
Total Premium							$2,100.57

Selected Plan:	IU Health Plans Gold Value
Rating Area:	Rating Area 7

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$406.87	0.976	2.230	1.410	$1,248.39
Spouse	40	Non-Smoker	$406.87	0.976	1.278	1.000	$507.41
Child 1	18	Non-Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 2	15	Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 3	13	Non-Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 4	10	Non-Smoker	$406.87	0.976	0.635	1.000	$0.00
Total Premium							$2,512.14

Appendix F
Indiana University Health Plans, Inc.
Federal AV Calculator Results

IU Health Plans Gold Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☑		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.80	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.4%
Metal Tier:	Gold

IU Health Plans Silver HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,600.00			
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.0%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.1%
Metal Tier:	Gold

IU Health Plans Silver HSA - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$400.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.1%
Metal Tier:	Platinum

IU Health Plans Silver Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.4%
Metal Tier:	Gold

IU Health Plans Silver Value - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

IU Health Plans Silver Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.7%
Metal Tier:	Gold

IU Health Plans Silver Enhanced - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$150.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$650.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

IU Health Plans Bronze HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.6%
Metal Tier:	Bronze

IU Health Plans Bronze Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	**Drug**	**Combined**	**Medical**	**Drug**	**Combined**
		$6,000.00			
		75.00%			
		$6,350.00			

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$350.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze

IU Health Plans Bronze Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,350.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$275.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☑		$50.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.8%
Metal Tier:	Bronze

Appendix G
Indiana University Health Plans, Inc.
Capital, Surplus, and RBC Information

Annual Statement for the year 2013 of the Indiana University Health Plans, Inc.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)				
2. Stocks (Schedule D):				
2.1 Preferred stocks				
2.2 Common stocks				
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens				
3.2 Other than first liens				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ encumbrances)				
4.2 Properties held for the production of income (less $ encumbrances)				
4.3 Properties held for sale (less $ encumbrances)				
5. Cash ($ 6,645,144, Schedule E - Part 1), cash equivalents ($, Schedule E - Part 2), and short-term investments ($, Schedule DA)	6,645,144		6,645,144	8,006,798
6. Contract loans (including $ premium notes)				
7. Derivatives (Schedule DB)				
8. Other invested assets (Schedule BA)				
9. Receivables for securities				
10. Securities lending reinvested collateral assets (Schedule DL)				
11. Aggregate write-ins for invested assets				
12. Subtotals, cash and invested assets (Lines 1 to 11)	6,645,144		6,645,144	8,006,798
13. Title plants less $ charged off (for Title insurers only)				
14. Investment income due and accrued	1,068		1,068	2,137
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	231,209	66,791	164,418	201,607
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ earned but unbilled premiums)				
15.3 Accrued retrospective premiums				
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers				
16.2 Funds held by or deposited with reinsured companies				
16.3 Other amounts receivable under reinsurance contracts				
17. Amounts receivable relating to uninsured plans				
18.1 Current federal and foreign income tax recoverable and interest thereon				
18.2 Net deferred tax asset				
19. Guaranty funds receivable or on deposit				
20. Electronic data processing equipment and software				
21. Furniture and equipment, including health care delivery assets ($)				
22. Net adjustment in assets and liabilities due to foreign exchange rates				
23. Receivables from parent, subsidiaries and affiliates	332,038		332,038	714,499
24. Health care ($ 449,493) and other amounts receivable	1,838,476	915,716	922,760	616,348
25. Aggregate write-ins for other than invested assets	1,110,648	156,922	953,726	510,111
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	10,158,583	1,139,429	9,019,154	10,051,500
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28. Total (Lines 26 and 27)	10,158,583	1,139,429	9,019,154	10,051,500

DETAILS OF WRITE-IN LINES				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	NONE			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501. Estimated Medicare Settlement Receivable	953,726		953,726	510,111
2502. Prepaid General and Administrative Expenses	156,922	156,922		
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page				
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	1,110,648	156,922	953,726	510,111

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ 0 reinsurance ceded)				
2.	Accrued medical incentive pool and bonus amounts				
3.	Unpaid claims adjustment expenses				
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Services Act	29,399		29,399	105,075
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	294,066		294,066	229,823
9.	General expenses due or accrued	818,192		818,192	1,431,649
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))				
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others				
13.	Remittances and items not allocated				
14.	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)				
15.	Amounts due to parent, subsidiaries and affiliates				12,550
16.	Derivatives				
17.	Payable for securities				
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified $ (0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans				
23.	Aggregate write-ins for other liabilities (including $ 0 current)	595,407		595,407	871,800
24.	Total liabilities (Lines 1 to 23)	1,737,064		1,737,064	2,650,897
25.	Aggregate write-ins for special surplus funds	XXX	XXX		
26.	Common capital stock	XXX	XXX	1,000	1,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	27,499,000	27,999,000
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	(20,217,910)	(20,599,397)
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX		
	32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	7,282,090	7,400,603
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	9,019,154	10,051,500

	DETAILS OF WRITE-IN LINES				
2301.	Estimated Medicare Settlement Liability	338,139		338,139	667,855
2302.	Other Amounts Payable	257,268		257,268	203,945
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	595,407		595,407	871,800
2501.		XXX	XXX		
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

NONE

NONE

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL - XR025

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		7,282,090	
(2)	Company Action Level=200% of Authorized Control Level	CAL	4,146,860	
(3)	Regulatory Action Level=150% of Authorized Control Level	RAL	3,110,145	
(4)	Authorized Control Level=100% of Authorized Control Level	ACL	2,073,430	
(5)	Mandatory Control Level=70% of Authorized Control Level	MCL	1,451,401	
(6)	Level of Action, if Any		NONE	

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	7,282,090
Authorized Control Level Risk-Based Capital on Line 15 of the Five Year Historical Data Page	2,073,430

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	98,250,957	
(8)	Underwriting Deductions	Page 4, Line 23	97,709,883	
(9)	Combined Ratio	Line (8)/Line(7)	99.400	
(10)	RBC Ratio	Line(1)/Line(4)	351.200	
(11)	Trend Test Result	If Line(10) is between 200% and 300% and Line (9) > 105%, then "Yes", otherwise "No"		No
(12)	Level of Action, if any, including Trend Test		NONE	

[Insert logo left/center/right]

CHILD-ONLY CONTRACT
[Issued through the Indiana Marketplace]
(herein called the "Contract")

[Product Name]

Issued by:

[Indiana University Health Plans, Inc.]
an Indiana domestic health maintenance organization
950 North Meridian Street
Indianapolis, Indiana 46204

[This coverage is issued through the Indiana Marketplace to provide coverage for a Dependent.] This Contract sets forth in detail the rights and obligations of the Subscriber. It is important that you **read this Contract carefully.** This Contract provides coverage only for enrolled Dependents. This Contract includes limitations and exclusions. You should familiarize yourself with its terms and conditions before receiving Health Care Services. Capitalized terms have the meaning set forth in the Definitions sections.

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, you may return it to us or the agent who sold it to you within 10 days after your receipt. Your premium will be refunded and this Contract with be void from its start. Any Health Care Services received during this 10-day period are solely your responsibility.

Benefits under this Contract may vary depending on other medical expense insurance you may have.

If you have questions related to the health insurance coverage provided under this Contract, you may contact us at [toll free number] [or the Indiana Marketplace at www.healthcare.gov or [toll free number].]

[signature]
President

[**DISCLAIMER:** The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace.]

TABLE OF CONTENTS

PAGE

ARTICLE 1. DEFINITIONS 1
ARTICLE 2. ELIGIBILITY AND ENROLLMENT. 9
ARTICLE 3. YOUR FINANCIAL OBLIGATIONS 16
ARTICLE 4. COVERED SERVICES 19
ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS 54
ARTICLE 6. OBTAINING COVERED SERVICES 63
ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES. 65
ARTICLE 8. PAYMENT FOR COVERED SERVICES 72
ARTICLE 9. COORDINATION OF BENEFITS 74
ARTICLE 10. TERMINATION OF COVERAGE 79
ARTICLE 11. GRIEVANCE PROCEDURES 83
ARTICLE 12. GENERAL PROVISIONS 86

ARTICLE 1. DEFINITIONS

[In this Contract, the terms “we”, “us” or “our” refer to [Indiana University Health Plans, Inc.] The term “you” refers to you, the Subscriber, Dependent or Covered Person, either collectively or individually as appropriate to the reference.]

[In this Contract, the terms “we”, “us” or “our” refer to [Indiana University Health Plans, Inc.]. The term “you” refers to you, the Subscriber, in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber, or the Dependent or Covered Person, either collectively or individually as appropriate to the reference.]

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.

Approved Clinical Trial – a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

(a) A trial that is approved or funded by one, or a combination, of the following.

(a) The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services.

(b) The United States Food and Drug Administration.

(c) The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(d) The United States Department of Veteran’s Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(e) The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).

(f) The Centers for Disease Control and Prevention.

(g) The Agency for Health Care Research and Quality.

(h) The Centers for Medicare and Medicaid Services (CMS).

(i) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks.

(j) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(k) A qualified non-governmental research entity in guidelines issued by the National Institutes of Health for center support grants.

(2) A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.

(3) A study or investigation done for drug trials which are exempt from the investigational new drug application.

For purposes of this definition, the term "life threatening condition" means any disease or condition from which death is likely unless the disease of condition is treated.

Behavioral Health – a physical or behavioral condition having an emotional or psychological origin or effect, including substance abuse. Behavioral Health Services include mental health services and substance abuse services.

Benefits – your right to payment for Covered Services under this Contract subject to the terms, conditions, limitations, and exclusions of this Contract.

Child or Children – a child of the Subscriber or Subscriber's spouse, including any of the following until the Child attains the age of 21.

- Natural child,
- Stepchild,
- Legally adopted child,
- Child placed for the purpose of adoption, or
- Child placed under legal guardianship or legal custody.

Child includes a child of any age who is incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 26 and the Subscriber principally supports the Child. Proof of the disability must be submitted to us within thirty-one (31) days of the child's 21st birthday. For two years we may require proof of the child's continuing disability and dependency at reasonable intervals. After two years, we may require proof of the child's disability and dependency no more than once per year.

Coinsurance – a percentage of the Allowed Amount that the Subscriber must pay for certain Covered Services. Coinsurance amounts are set forth in the Schedule of Benefits.

Contract – this individual contract issued by [Indiana University Health Plans, Inc.] which provides Benefits for Covered Services received by and enrolled Dependents. The term Contract includes the Schedule of Benefits, any application, amendments and riders.

Copayment – a fixed amount the Subscriber pays to a Provider for a Covered Service. The amount of a Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

Cosmetic Services – Health Care Services primarily intended to preserve, change or improve a Covered Person's appearance or are furnished for psychiatric or psychological reasons.

Cost Sharing – the amount you are required to pay for Covered Services. Cost Sharing can be in the form of Copayments, Coinsurance or Deductibles.

Covered Person –any Dependent who meets all applicable eligibility requirements for coverage under this Contract, is enrolled as provided in this Contract, and for whom the required premium payment has been received by us.

Covered Services – Health Care Services provided to a Covered Person performed, prescribed, directed or authorized by a Provider and for which this 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 this Contract is in force.
- Not experimental/investigative.
- Authorized in advance by us if Precertification is required under this Contract.
- Not excluded or limited by this Contract.

Deductible – the amount the Subscriber must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The amount of the Deductible is set forth in the Schedule of Benefits.

Dependent – an individual who satisfies the eligibility requirements to enroll as a Dependent as set forth in Article 2.

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 [website] 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.

Durable Medical Equipment – Medical equipment that:

- can withstand repeated use and is not disposable,
- is used to serve a medical purpose,
- is generally not useful to a person in the absence of a Sickness or injury,
- is appropriate for use in the home, and
- is the most cost-effective type of medical apparatus appropriate for the condition.

Effective Date – the date when coverage under this Contract begins.

Emergency Medical Condition or Emergency – a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent 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 woman, the health of the

woman or her unborn child) in serious jeopardy.
- Serious impairment to a person's bodily functions.
- Serious dysfunction of a bodily organ or part of a person.

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, 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, 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 woman 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 woman or the unborn child.

FDA – the United States Food and Drug Administration.

Grace Period – the time period for payment of premium set forth in Article 3 Section B.

Health Care Services – medical or health care services, whether or not covered under this 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.

Indiana Marketplace – the health benefit exchange established by the Affordable Care Act for the state of Indiana.

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

Medically Necessary – those Health Care Services that we determine to be all of the following.

(4) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the Covered Person's illness, injury or disease.

(5) Required for the direct care and treatment or management of the Covered Person's illness, injury or disease.

(6) If not provided, the Covered Person's condition would be adversely affected.

(7) Provided in accordance with generally accepted standards of medical practice.

(8) Not primarily for the convenience of the Covered Person, your family, the physician or another prescribing Provider.

(9) 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 Covered Person'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 Covered Person'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 used in this 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 – 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 this Contract.

Non-Participating Hospital – a Hospital that has not entered into a contractual agreement with us or is not otherwise engaged by us to provide Health Care Services to Covered Persons under this 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 Covered Persons under this Contract.

[**Open Enrollment Period** – the number of days each year during which individuals may enroll in a Qualified Health Plan through the Indiana Marketplace.]

[**Open Enrollment Period** – the number of days each year during which individuals may enroll for coverage under this Contract.]

Out of Pocket Maximum – the maximum amount you will pay for Covered Services in a Plan Year.

Outpatient – receipt of Health Care Services while not an Inpatient.

Participating Hospital – a Hospital 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 Covered Persons under this Contract.

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 Covered Persons under this Contract.

Plan Year – the calendar year during which this Contract is in effect. This Plan Year will be the 12 month calendar year except that if the Subscriber's Effective Date is after January 1st the Plan Year will begin on the Effective Date and end December 31st.

Precertification – 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.

Prescription Drug – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product, insulin, diabetic supplies, and syringes.

Prescription Legend Drug – A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

Primary Care Physician or 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 a Covered Person's medical care under this Contract.

Provider – a doctor, Hospital, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

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.

(1) The Health Care Service that is the subject of the Approved Clinical Trial.

(2) 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.

(3) 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.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) 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.

(6) A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.

(7) A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Qualified Health Plan – a health plan offered on the Indiana Marketplace that satisfies the requirements set forth under the Affordable Care Act (42 U.S.C. 18021(a)(1)).

[**Qualified Individual** – an individual who has been determined by the Indiana Marketplace to be eligible to enroll in a Qualified Health Plan.]

Schedule of Benefits – the part of this Contract that sets forth Cost Sharing, Out of Pocket Maximums, limitations and other information regarding a Covered Person's coverage under this Contract.

Service Area – the counties in which we are authorized to offer a qualified health plan. Our Service Area is [insert list of counties].

Sickness – a physical illness, disorder, or disease. Sickness does not include Behavioral Health conditions.

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.

[**Special Enrollment Periods** – enrollment periods administered by the Indiana Marketplace that occur outside of the Open Enrollment Period. Qualified Individuals and their dependents who are eligible for a Special Enrollment Period may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another during a Special Enrollment Period set for them by the Indiana Marketplace.]

[**Special Enrollment Periods** – enrollment periods administered by us that occur outside of the Open Enrollment Period.]

Spouse – the Subscriber's legal spouse.

Subscriber – an individual whose name is on the Contract and has enrolled a Dependent for coverage under this Contract. A Subscriber is the legal parent or legal guardian of the Covered Person. The Subscriber is not a Covered Person under this Contract.

Therapeutic Abortion – an abortion performed to save the life or health of the mother, or as a result of incest or rape

Urgent Care Claim – 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 a Covered Person's life, health or ability to reach and maintain maximum function.
- In the opinion of physicians familiar with a Covered Person's condition, would subject a Covered Person to severe pain that cannot be adequately managed unless we approve the Claim.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT.

[This Contract is available through the Indiana Marketplace. The Benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Indiana Marketplace to be Qualified Individuals.]

E. **The Covered Person as an Individual:** To be eligible for coverage as a Subscriber, an individual must meet the eligibility requirements listed below at the time of application and throughout the Plan Year.

(1) [Determined by the Indiana Marketplace to be a Qualified Individual for purposes of enrollment in a Qualified Health Plan.] [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective.]

(2) [Not incarcerated.] [Agree to pay the cost of the Premium that we require.]

(3) [A United States citizen or lawfully present non-citizen.] [Submit proof satisfactory to us to confirm Dependent eligibility.]

(4) To be eligible as a Dependent, the person must be the Subscriber's Child.

(5) Under age 21.

(6) A resident of the State of Indiana.

(7) Not entitled to or enrolled in Medicare or Medicaid.

(8) Not covered by any other group or individual health benefit plan.

F. [**Other Rules About Eligibility.** No one will be denied enrollment or re-enrollment in this Contract because of health status, or the existence of a pre-existing physical or mental condition.]

G. **Open Enrollment**.

(1) [Notice of Annual Open Enrollment. Each calendar year the Indiana Marketplace will provide you with a written annual open enrollment notification no earlier than September 1, and no later than September 30.]

[Notice of Annual Open Enrollment. Each calendar year we will provide you with a prior written notice of the Open Enrollment Period.]

(2) [2015 Open Enrollment Period. For this Plan Year beginning on January 1, 2015, the Open Enrollment period begins on November 15, 2014 and extends through February 15, 2015.]

(3) [Effective Dates for Coverage Selected During 2015 Open Enrollment. For this Plan Year beginning on January 1, 2015, the following Effective Dates will apply:

(a) January 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace on or before December 15, 2014.

(b) February 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from December 16, 2014 through January 15, 2015.

(c) March 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from January 16, 2015 through February 15, 2015.]

(4) [Effective Dates for Coverage Selected During Annual Open Enrollment. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if we receive the application and initial premium payment between the 1st and 15th of the month. If we receive the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st)]

H. [**Special Enrollment Period.**

(1) Special Enrollment Triggering Events. The Indiana Marketplace must allow Qualified Individuals and Dependents to enroll in a Qualified Health Plan or change from one Qualified Health Plan to another as a result of experiencing any of the following triggering events:

(a) Loss of Minimum Essential Coverage.

(b) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(c) Gaining status as a citizen, national, or lawfully present individual.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services ("HHS"), or its instrumentalities as evaluated and determined by the Indiana Marketplace. In such cases, the Indiana Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to a new service area of the Indiana Marketplace.

(h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(i) Demonstration to the Indiana Marketplace, in accordance with guidelines issued by HHS, that the Dependent meets other exceptional circumstances as the Indiana Marketplace may provide.

(j) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.)

(2) Indiana Marketplace Administration of Special Enrollments. For additional information on special enrollment triggering events and how to enroll in or change a Qualified Health Plan during a Special Enrollment Period, you should contact the Indiana Marketplace at [toll free number] or visit the Indiana Marketplace website at [www.healthcare.gov].

(3) Notice Requirement for Special Enrollments. Unless specifically stated otherwise in the applicable Indiana Marketplace rules, a person has sixty (60) days from the date of a special enrollment triggering event to select a Qualified Health Plan.

(4) Special Enrollment Effective Dates. The Effective Date for coverage obtained under this Contract during a Special Enrollment Period depends on the type of triggering event that qualified the individual and/or dependent for the Special Enrollment Period as well as the date the Indiana Marketplace received the Qualified Individual's Qualified Health Plan selection.

(a) For a Qualified Health Plan selection received from the first (1st) through the fifteenth (15th) day of any month, the Effective Date will be the first (1st) day of the following month; and

(b) For a Qualified Health Plan selection received from the sixteenth (16th) through the last day of any month, the Effective Date will be the first (1st) day of the second following month.]

D. [**Changes Affecting Eligibility and Special Enrollment Periods.**

(1) Special Enrollment Triggering Events. A Special Enrollment Period is a period during which an eligible individual who experiences certain triggering events or changes in eligibility may enroll in this Contract, outside of the Open Enrollment period.

(2) Length of Special Enrollment Period. Unless otherwise stated, an eligible individual has 60 days from the date of a triggering event to enroll an eligible individual in this Contract.

(3) Triggering Events

(a) Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, misrepresentation of a material fact or failure to pay premium.

(b) Loss of Minimum Essential Coverage due to dissolution of marriage.

(c) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Indiana Marketplace.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to new service area of the Indiana Marketplace.

(h) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.]

E. Adding New Dependents Under A Special Enrollment Period

(1) Newly Born Children. If the Subscriber has a new Dependent as a result of birth, coverage for the new Dependent is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for the new Dependent shall continue beyond the initial thirty-one (31) days, provided the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace to add the new Dependent to this Contract] [submits a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, if any[, within 60 days after the birth of the new Dependent]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days after the date of birth. The Effective Date will be the date of birth.]

If a Covered Person has a newborn child, coverage for the newborn child is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for the newborn child shall continue beyond the initial thirty-one (31) days, provided the newborn child meets the definition of Child under this Policy

and the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace] [submits a form to us] to add the Child to this Contract and we receive payment for additional applicable premium, if any. If the newborn child does not meet the definition of Child under this Policy before the end of the initial thirty-one (31) days, coverage for the newborn child will terminate upon the thirty-second (32nd) day.

(2) Adopted Children. If the Subscriber has a new Dependent as a result of adoption, coverage for the new Dependent is automatically provided from the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the Subscriber custody of the child for purposes of adoption, for up to thirty-one (31) days. Coverage for the new Dependent shall continue beyond the initial thirty-one (31) day period provided the Subscriber [requests a Special Enrollment Period through the Indiana Marketplace to add the new Dependent to this Contract] [submits a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, in any[, within 60 days following the date of adoption or placement for adoption]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of adoption or placement of adoption.] The Effective Date will be the earlier of the date of adoption or placement of adoption.

(3) Adding a Child due to Award of Guardianship. If the Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a Child, an application to cover the Child under this Contract must be submitted to [the Indiana Marketplace] [us] within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

(4) Qualified Medical Child Support Order. If the Subscriber is required by a Qualified Child Support Order or court order, as defined by applicable state and federal law, to enroll his or her Child under this Contract, and the Child is otherwise eligible for the coverage, [the Indiana Marketplace] [we] will permit the Subscriber's Child to enroll in this Contract, and we will provide the benefits of this Contract in accordance with the applicable requirements of such court order.

A Child's coverage under this provision will not extend beyond the Dependent attaining age 26. Any claims payable under this Contract will be paid, at our discretion, to the Child or the Child's custodial parent or legal guardian, for any expenses paid by the Child, custodial parent or legal guardian. We will make information available to the Child, custodial parent or legal guardian on how to obtain benefits and submit claims to us directly.

(5) New Dependent as a Result of Marriage or Loss of Minimum Essential Coverage. If the Subscriber has a new Dependent as a result of marriage, or due to the new Dependent's loss of Minimum Essential Coverage, the Subscriber may elect to enroll the new Dependent in this Contract, provided the Subscriber [requests a Special Enrollment Period from the Indiana Marketplace to add your new Dependent to this Contract] [submits to us a form to add your new

Dependent] and we receive payment for additional applicable premium, if any[, within 60 days from the date of marriage or the loss of Minimum Essential Coverage]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of marriage or the loss of Minimum Essential Coverage.] The Effective Date will be on the first (1st) day of the month following the date of marriage or loss of Minimum Essential coverage.

(a) "Loss of Minimum Essential Coverage" includes loss of eligibility for coverage as a result of any of the following:

(a) Legal separation or divorce.

(b) Cessation of dependent status (such as reaching the maximum age to be eligible as a Dependent under this Contract).

(c) Death of an employee; termination of employment; reduction in the number of hours of employment; or any loss of eligibility for coverage after a period that is measured by any of the foregoing.

(d) Individual who no longer resides, lives or works in the service area.

(e) A situation in which a health benefit plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Termination of employer contributions.

(g) Exhaustion of COBRA continuation of coverage.

(b) "Loss of Minimum Essential Coverage" does not include termination or loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(b) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact

If the Subscriber does not enroll a new Dependent during the time periods stated above, the new Dependent will not be added to the coverage under this Contract until the next Open Enrollment Period.

F. Notification of Changes.

(1) Responsibility to Notify [the Indiana Marketplace] [Us]. The Subscriber is required to notify [the Indiana Marketplace] [us] of any changes in a Covered Person's eligibility for Benefits under this Contract. [The Indiana Marketplace] [We] must be notified of any changes in eligibility as soon as possible, but not later than thirty (30) days from the date of the change in eligibility status. This

may include changes in address, marriage, divorce, death, incarceration, change of Dependent disability or dependency status, change in Medicare or Medicaid eligibility status, etc. Notice of a change in eligibility must be provided to [the Indiana Marketplace in a form required and approved by the Indiana Marketplace] [us in writing and on a form approved by us]. Such notifications must include all information required to effectuate all necessary changes.

(2) Failure to Notify [Indiana Marketplace] [Us]. Failure to notify [the Indiana Marketplace] [us] of persons no longer eligible for coverage under this Contract will not obligate us to provide services to those no longer eligible. Our acceptance of payments for persons no longer eligible for services will not obligate us to pay for such services.

(3) Effective Date of Termination Due to Change in Eligibility. Regardless of whether we receive timely notice, a Covered Person's coverage will terminate on the [last day of the month following the date] [day] such Covered Person ceases to be eligible for coverage under this Contract. [We have the right to bill the Subscriber for the cost of any Health Care Services provided to a Covered Person during the period such Covered Person is not eligible under this Contract.] If the Subscriber thinks there are reasons coverage of the person experiencing the change should continue, the Subscriber must notify [the Indiana Marketplace] [us] of the reasons for the continuation of the coverage no later than thirty-one (31) days after the date coverage for the Dependent would otherwise terminate.

(4) [Statements and Forms. You shall complete and submit to us applications and other forms or statements we may request. You represent to the best of their knowledge and belief that all information contained in such applications, forms, questionnaires, and statements submitted to us is true, correct and complete. You understand that all rights to Benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you or a Covered Person may result in termination or rescission of coverage.]

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A. Premium

(1) The Subscriber must pay premium to us each month for coverage under this Contract. The Subscriber's premium rate is determined using the following acceptable rating factors: age, tobacco use, family size and geography.

(a) Tobacco use impacts the determination of the premium. [Upon enrollment through the Indiana Marketplace] [During the enrollment application process], the Subscriber will attest to tobacco use by his or her Dependents. If the Subscriber reports false or incorrect information about tobacco use, we may retroactively apply the appropriate tobacco rating factor to the Subscriber's premium as if the correct information had been accurately reported from the Effective Date.

(b) A Covered Person's age impacts the determination of the premium rate. If a Covered Person's age has been misstated, we will adjust the premiums to the amount premiums would have been if purchased at the correct age.

(2) The Subscriber will receive a monthly bill for your premium. The Subscriber's payment is due by the date stated in the Subscriber's bill subject to the any applicable Grace Period stated in this Contract. The Subscriber must pay the premium when it is due for coverage to continue.

(3) We reserve the right to change the premium on an annual basis. We will provide the Subscriber with thirty (30) days prior written notice of any change in the premium.

(4) The Subscriber's premium may change if Dependents are enrolled or disenrolled in the coverage under this Contract. If a premium increase is necessary, we will bill the Subscriber for the additional amount due. If this amount is not paid, this Contract will be cancelled at the end of the applicable Grace Period and the Subscriber will receive a refund of any unearned premium. If a decrease in premium is appropriate we will notify the Subscriber of the decrease and refund any excess premium to the Subscriber.

(5) If premium has been paid for any period of time after the date the Subscriber cancels this Contract, we will refund that premium to the Subscriber. The refund will be for the period of time after coverage under this Contract ends. If a Covered Person dies while this Contract is in force, we will refund any premium paid for such Covered Person for any period after the date of the Covered Person's death.

B. Grace Period

(1) [General Grace Period.] Following payment of the initial premium, a Grace Period of thirty (30) days shall be granted for the payment of any premium. This Grace Period shall not extend beyond the date this Contract terminates. During

the Grace Period this Contract shall continue in force. Any claims incurred and submitted during the Grace Period will not be considered for payment until premium is received. If premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of coverage.

(2) [Grace Period for Persons Receiving Advance Payments of the Premium Tax Credit. If the Subscriber or Covered Person is receiving advance payments of the premium tax credit and at least one full month's premium has been paid during this Plan Year, a Grace Period of three (3) consecutive months shall be granted for the payment of any premium. During this 3-month Grace Period, we shall do all of the following listed below.

(a) Pay for Covered Services during the first (1st) month of the Grace Period and may pend claims for Covered Services rendered to the Covered Person in the second and third months of the Grace Period.

(b) Notify the Department of Health and Human Services of such non-payment

(c) Notify Providers of the possibility for denied claims during the second and third months of the Grace Period.]

C. Deductible.

(1) The Deductible is the amount the Subscriber must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The Deductible is set forth in the Schedule of Benefits.

(2) Copayments do not count towards the Deductible.

D. Coinsurance

(1) Coinsurance is a percentage of the Allowed Amount that the Subscriber must pay for Covered Services. The Subscriber is responsible for payment of Coinsurance after the Subscriber has met the Deductible and until the Subscriber reaches the Out of Pocket Maximum. Coinsurance is set forth in the Schedule of Benefits.

(2) Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

E. Copayments

(1) Copayments are a fixed amount the Subscriber pays to a Provider for a Covered Service. Copayments are typically paid when the Subscriber receives the Covered Service. The amount of the Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

(2) Copayments do not apply to the Deductible. Copayments apply towards the Out of Pocket Maximum.

F. Out of Pocket Maximum

(1) The Out of Pocket Maximum is the maximum amount the Subscriber will pay for Covered Services in a Plan Year. The Out of Pocket Maximum is listed on the Schedule of Benefits.

(2) Once the Out of Pocket Maximum is reached, we will pay 100% of the Benefits for Covered Services.

(3) Copayments, Coinsurance and the Deductible apply towards the Out of Pocket Maximum.

G. Payments for Non-Covered Services. The Subscriber is responsible for payment of all expenses for Non-Covered Services.

ARTICLE 4. COVERED SERVICES

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides Benefits for the following Covered Services. Payment for Covered Services is limited by any applicable Coinsurance, Copayment, or Deductible set forth in this Contract including the Schedule of Benefits. To receive maximum Benefits for Covered Services, the terms of this Contract must be followed, including receipt of care from a Primary Care Physician and Participating Providers as well as obtaining any required Precertification.

You are responsible for all expenses incurred for Non-Covered Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

A. Ambulance Services

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

(a) From your home, scene of accident or medical Emergency to a Hospital,

(b) Between Hospitals,

(c) Between a Hospital and Skilled Nursing Facility, or

(d) From a Hospital or Skilled Nursing Facility to your home.

(2) Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

(3) Other vehicles which do not meet the definition of Ambulance Services are not Covered Services. Ambulette services are Covered Services when appropriate.

(4) Ambulance Services are a Covered Service only when Medically Necessary, except:

(a) When ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse, or

(b) When a Covered Person is required by us to move from a Non-Participating Provider to a Participating Provider.

(5) Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health.

(6) Non-Covered Services for Ambulance include but are not limited to:

(a) A trip to a physician's office or clinic,

(b) A trip to a morgue or funeral home, or

(c) Any ambulance usage for the convenience of a Covered Person, family or Provider.

B. Behavioral Health Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Covered Services include:

(a) Inpatient services. Individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

(b) Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

(c) Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health conditions. Intensive Outpatient programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient programs may offer group, DBT, individual, and family services.

(d) Outpatient Treatment, or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

(2) Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

(3) To assist you in obtaining appropriate and quality care, we will ask for a treatment plan after you have been evaluated after 10 Outpatient visits. We may discuss the goals of treatment and changes in the treatment plan, including

alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

(4) Non-Covered Services include the following.

(a) Custodial or domiciliary care.

(b) Supervised living or halfway houses.

(c) Services or care provided or billed by a residential treatment center, school, halfway house.

(d) Custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(e) Services related to non-compliance of care if the Covered Person ends treatment for substance abuse against the medical advice of the Provider.

C. Routine Care Costs as Part of a Cancer or Other Life Threatening Disease or Condition Clinical Trial

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits are available for Routine Care Costs rendered as part of an Approved Clinical Trial if the services are otherwise Covered Services under this Contract.

(2) Your Primary Care Physician must give us notice of your participation in an Approved Clinical Trial.

(2) Non-Covered Services include the following.

(a) A Health Care Service that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient.

(b) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service or investigational drug that is the subject of the clinical trial.

(c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.

(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the clinical trial.

(e) An item or drug provided by the clinical trial sponsors free of charge for any patient.

(f) A service, item, or drug that is eligible for reimbursement by a person or entity other than us, including the sponsor of the clinical trial.

D. Dental Services Related to an Injury

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient services, Physician Home Visits and Office Services, Emergency Services and Urgent Care Center Services for dental work and oral surgery are Covered Services if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Covered Person's condition.

(2) Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

(3) For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

(4) Covered Services include, but are not limited to the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations
- Prosthetic services
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia

(5) Anesthesia and Hospital charges for dental care for a Covered Person less than 19 years of age or a Covered Person who is physically or mentally disabled, are covered if the Covered Person requires dental treatment to be given in a Hospital or Outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Covered Person's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

E. Diabetic Equipment, Education and Supplies

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when ordered in writing by a physician or a podiatrist and provided by a physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

(2) Covered Services include physician prescribed equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances”, “Preventive Care Services”, and “Physician Home Visits and Office Services”.

F. Diagnostic Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services include the following.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).

- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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

(3) For Diagnostic services other than those approved to be received in a physician's office, you may be required to use a laboratory that is a Participating Provider.

(4) When Diagnostic radiology is performed in a Participating Provider's Office, no Copayment is required, however, any Coinsurance will still apply.

G. Emergency Care Services and Urgent Care Center Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit limitation. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits for treatment of an Emergency Medical Condition and Emergency screening and stabilization services without Precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions.

(2) Benefits for Emergency Care include facility costs and physician services, supplies and Prescription Drugs charged by that facility.

(3) Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Copayment or Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify us or verify that your physician has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary. If your Provider is a Non-Participating Provider, you will be financially responsible for any care we determine is not Medically Necessary.

(4) Often an urgent rather than an Emergency Medical Condition exists. An urgent medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Such medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Primary Care Physician prior to receiving care for an urgent medical problem and your Primary Care Physician

authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Care Services.

H. Home Care Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Covered Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Care Services.
- Nutritional Guidance.
- Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Health Care Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Care Services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services in the home (except for Massage, Music, and Manipulation Therapy). Home Care visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

(3) Non Covered Services include the following.

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

(4) Home infusion therapy will be paid only if you obtain Precertification. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

I. Hospice Services

For all Covered Services, see the schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit limitations. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) 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 (6) months or less, as certified by the attending physician and hospice medical director. Covered Services will continue if the Covered Person lives longer than six (6) months, provided the hospice medical director or other hospice physician recertifies that the Covered Person is terminally ill.

(2) Covered Hospice Services include the following.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Care Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

(3) Non-Covered Services include services provided by volunteers and housekeeping services.

J. Inpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Inpatient services include the following.

(a) Charges from a Hospital, Skilled Nursing Facility or other Provider for room, board and general nursing services.

(b) Ancillary services.

(c) Professional services from a physician while an Inpatient.

(2) Room, Board, and General Nursing Services include either of the following.

(a) A room with two or more beds or a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

(b) A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

(3) Ancillary (Related) Services include any of the following.

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

(4) Professional Services include the following.

- Medical care visits limited to one visit per day by any one physician.
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, and EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

(5) When a Covered Person is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

K. Maternity Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

(2) If the Covered Person is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider for the Health Care Services to be Covered Services. If the Covered Person is pregnant on her Effective Date and is in her second or third trimester of pregnancy, she may receive Benefits for Health Care Services from a Non-Participating Provider if she requests and receives written approval from us.

(3) If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance or Copayment.

(4) If Maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

(5) Coverage for the Inpatient postpartum stay for a Covered Person and her newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if both or the following are met.

(a) In the opinion of your attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the following.

- The antepartum, intrapartum, and postpartum course of the mother and infant.
- The gestational stage, birth weight, and clinical condition of the infant.
- The demonstrated ability of the mother to care for the infant after discharge.
- The availability of post discharge follow-up to verify the condition of the infant after discharge.

(b) The mother of the newborn child agrees with the recommendation for a shorter length of stay.

(6) Covered Services include at-home post-delivery care visits at your residence by a physician or nurse performed no later than 48 hours following discharge from the Hospital. Coverage for this visit includes, but is not limited to parent education, assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At your discretion, this visit may occur at the physician's office.

(7) Covered Services include the following tests and examinations given at the earliest feasible time to the newborn child for the detection of the following disorders.

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

L. Medical Supplies, Durable Medical Equipment and Appliances

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Medical and Surgical Supplies. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a physician's office, including but not limited to, Depo-Provera and Remicade. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

(a) Covered Services include the following.

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.

- Clinitest.
- Needles/syringes.
- Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not Covered Services.

(b) Non-Covered Services include the following.

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Medijectors.

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

(3) Durable Medical Equipment - The rental (or, at our option, the purchase) of Durable Medical Equipment prescribed by a Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples of Durable Medical Equipment include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price.

(a) We will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Covered Person, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is a Covered Service.

(b) Covered Services include the following.

- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pump for IV fluids and medicine.
- Glucometer.

- Tracheotomy tube.
- Cardiac, neonatal and sleep apnea monitors.
- Augmentive communication devices are Covered Services when we approve based on the Covered Person's condition.
- CPAP machines when indicated for sleep apnea.

(c) Non-Covered Services include the following.

- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats.
- Rental of equipment if the Covered Person is in a Facility that is expected to provide such equipment.
- Translift chairs.
- Treadmill exerciser.
- Tub chair used in shower.

(4) Prosthetics. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

(a) Prosthetic devices should be purchased not rented. Applicable taxes, shipping and handling are Covered Services.

(b) Covered Services include the following.

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Plan Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction

is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered Services. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be a Covered Service.

- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Plan Year).

(c) Non-Covered Services include the following.

- Dentures, replacing teeth or structures directly supporting teeth.
- 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.

(5) Orthotic Devices. The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered Services. The casting is a Covered Service when an orthotic appliance is billed with it, but not if billed separately.

(a) Covered Services include the following.

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

(b) Orthotic appliances may be replaced one time per Plan Year unless specifically approved in writing by us. Additional replacements will be allowed for Covered Persons under age 18 due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

(c) Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

(d) Non-Covered Services include the following.

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

(6) Prosthetic limbs & Orthotic custom fabricated brace or support. Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be a Covered Service if they are determined by your physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities, and are not solely for comfort or convenience.

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

(b) Prosthetic limbs and orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

(7) Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below, as approved by us.

(a) The repair, adjustment or replacement of the purchased equipment, supply or appliance is a Covered Service if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.

- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

(b) Replacement of purchased equipment, supplies or appliance may be a Covered Service if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

(c) Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

M. Outpatient Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital or other facility as determined by us. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation.

(2) Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to Article 3 Section B for Behavioral Health Services covered by this Contract.

(3) Professional charges only include services billed by a physician or other professional.

(4) When Diagnostic Services or other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Service, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

(5) For Emergency Care refer to the section titled Emergency Services.

N. Autism Spectrum Disorder Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Autism Spectrum Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(2) Coverage is provided for the treatment of Autism Spectrum Disorders, including behavioral therapies such as Applied Behavior Analysis (ABA). Benefits are limited to Health Care Services prescribed by your physician in accordance with a treatment plan. Coverage for Health Care Services will be provided as prescribed by your treating physician in accordance with the treatment plan.

(3) Any exclusion or limitation in this Contract in conflict with the coverage described in this section will not apply.

(4) Coverage for Autism Spectrum Disorders will not be subject to limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Contract.

O. Physician Home Visits and Office Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service a Health Care Service must be Medically Necessary.

(1) Covered Services include care provided by a physician, including employees of the physician such as an advanced practice nurse or physician assistant, in his/her office or your home. Refer to the sections titled Preventive Care, Maternity Care, Home Care Services, and Behavioral Health Care Services for services covered by this Contract. For Emergency Care refer to the Emergency Services section.

(2) Office visits for medical care and consultations to examine, diagnose, and treat a Sickness or injury performed in the physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a physician's office, no Copayment is required however Coinsurance will apply.

(3) Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

(4) Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

(5) Surgery and surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

(6) Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a physician or other professional Provider.

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

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

(2) Preventive Care Services in this section shall meet requirements as determined by federal and state law.

(a) Health Care Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF. Covered Services include the screenings for following.

- Breast cancer.
- Cervical cancer.
- Colorectal cancer.
- High Blood Pressure.
- Type 2 Diabetes Mellitus.
- Cholesterol.
- Child and Adult Obesity.
- For Covered Persons age 15 – 65 and other ages at increased risk, Human Immunodeficiency Virus (HIV)
- Depression for adults
- Screening for alcohol misuse

(b) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(c) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Well Baby visits and care.
- Newborn screening for hearing
- Lead screening for children at risk for exposure
- Depression screening for adolescents

(d) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Women's contraceptives, sterilization procedures, and counseling. This includes generic drugs only, unless there is no generic equivalent, obtained from a Participating Pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms and intrauterine devices (IUDs) are also covered. When generic equivalents are available, prescription brand name contraceptives will not be covered under the Preventive Care benefit. Instead, prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the Prescription Drug Benefits section.
- Breastfeeding support, supplies, and counseling.
- Gestational diabetes screening.

(3) Covered Services also include the following services required by state law:

(a) Breast Cancer Screening. The following are Covered Services.

(a) If the female Covered Person is at least 35 years of age, one (1) baseline breast cancer screening mammography performed before she becomes 40 years of age.

(b) If the female Covered Person is less than 40 years of age and is high risk, one (1) breast cancer screening mammography performed every year. A woman is considered "high risk" if she meets at least one (1) of the following.

(A) Has a personal history of breast cancer.

(B) Has a personal history of breast disease proven benign by biopsy.

(C) Has a mother, sister, or daughter who has had breast cancer.

(D) Is at least 30 years of age and has not given birth.

(c) Any additional mammography views that are required for proper evaluation.

(d) Ultrasound services, if determined Medically Necessary by the physician treating the Covered Person.

(b) Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Service for a Covered Person under the age of fifty (50) if the Covered Person is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsymptomatic Covered Person, in accordance with the current American Cancer Society guidelines.

(c) Diagnostic Prostate Cancer Screening. If male Covered Person is at least 50 years of age, one (1) prostate specific antigen test annually is a Covered Service. If a male Covered Person is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test annually is a Covered Service.

Q. Surgical Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes the following.

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

(2) The surgical fee includes normal post-operative care.

(3) We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact us for more information.

(4) Covered Surgical Services include the following.

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

R. Reconstructive Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

(2) Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract.

(3) Covered Services are limited to the following.

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

(4) A Covered Person who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive coverage for the following.

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

S. Sterilization.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

Sterilization is a Covered Service.

T. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

(2) Covered Services include removable appliances for repositioning and related surgery, medical care, and diagnostic services.

(3) Non-Covered Services include the following:

- Fixed or removable appliances that involve movement or repositioning of the teeth.
- Repair of teeth (fillings).
- Prosthetics (crowns, bridges, dentures).

U. Therapy Services.

Benefits are provided for therapy services that can be Rehabilitative or Habilitative. For purposes of this section and the Schedule of Benefits, the following definitions apply:

- Rehabilitation refers to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech therapy and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Physical therapy.

(a) Physical therapy includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve

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

(b) Non-Covered Services include the following.

- Maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness.
- Repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients).
- Range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities.
- General exercise programs, diathermy, ultrasound and heat treatments for pulmonary conditions.
- Diapulse.
- Work hardening.

(3) Speech Therapy. Speech therapy for the correction of a speech impairment.

(4) Occupational Therapy. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

(a) Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

(b) Non-Covered Services include the following.

- Supplies (looms, ceramic tiles, leather, utensils).
- Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again.
- General exercises to promote overall fitness and flexibility.
- Therapy to improve motivation.
- Suction therapy for newborns (feeding machines).
- Soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial.
- Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

(5) Manipulation Therapy. Manipulation Therapy includes osteopathic/chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy

includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

(a) Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any limitation for Manipulation Therapy services as specified in the Schedule of Benefits.

(b) Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

(6) Other Therapy Services

(a) Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

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

(c) Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage this Contract will not require you to receive dialysis treatment at a Participating Provider that is a dialysis facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Participating Dialysis Facility is more than 30 miles from your home, you may, upon our prior written consent, receive treatment at a Non-Participating Provider that is a dialysis facility nearest to your home as Covered Service.

(d) Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

(e) Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to:

- Introduction of dry or moist gases into the lungs.
- Nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication.
- Continuous positive airway pressure ventilation (CPAP).
- Continuous negative pressure ventilation (CNP).
- Chest percussion.
- Therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers.

- Broncho-pulmonary drainage.
- Breathing exercises.

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

V. Physical Medicine and Rehabilitation Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

(2) The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting. Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

(3) Non-Covered Services include the following.

- Admission to a Hospital mainly for physical therapy.
- Long term rehabilitation in an Inpatient setting.

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

W. Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Cost Sharing.

(2) "Covered Transplant Procedure" includes any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

(3) "Transplant Benefit Period" starts one day prior to a covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.

(4) Transplant services require Precertification.

(5) Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are a Covered Service as routine Diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

(6) Transportation and Lodging. This Contract will provide assistance with reasonable and necessary travel expenses as determined by us when you obtain Precertification and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must

submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when claims are filed.

(7) Non-Covered Services for transportation and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

X. Prescription Drug Benefits

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Pharmacy Benefits Manager (PBM).

(a) The Prescription Drug benefits are managed by our Pharmacy Benefits Manager or PBM. The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy, a Specialty Pharmacy, and provides clinical management services. The management and other services the PBM provides include, making recommendations to, and updating, the “covered Prescription Drug list” (the “covered Prescription Drug list” is referred to as the “Formulary”), managing a network of retail pharmacies, operating a mail service pharmacy, and operating a Specialty Pharmacy network.

(b) The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of Prescription Drug benefits, such as review for possible excessive use, recognized and recommended dosage

regimens, drug interactions or drug/pregnancy concerns. You may request a copy of the Formulary by calling the Customer Service telephone number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage.

(c) For certain Prescription Drugs, the prescribing Provider may be asked to provide additional information before the PBM and/or we can determine Medical Necessity. We may, in our sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer.

(d) Precertification may be required for certain Prescription Drugs (or the prescribed quantity of a particular Prescription Drug). At the time you fill a prescription, the Participating Pharmacy is informed of the Precertification requirement through the Participating Pharmacy's computer system. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee which is reviewed and adopted by us.

(e) For a list of the current Prescription Drugs requiring Precertification, please contact the Customer Service telephone number on the back of your Identification Card or go to our website at [insert url to formulary]. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage. Your Provider or Participating Pharmacy may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under this Contract.

(2) Therapeutic Substitution of Prescription Drugs. This is a voluntary program designed to inform Covered Persons and Providers about possible substitutes to certain Prescription Drugs. We, or the PBM, may contact you and your prescribing Provider to make you aware of substitution options. Therapeutic substitutes may also be initiated at the time the Prescription Drug is dispensed.

(a) Only you and your Provider can determine whether the therapeutic substitute is appropriate for you.

(b) For questions or issues involving therapeutic substitutes, call the Customer Service telephone number on the back of your Identification Card.

(c) The therapeutic substitutes list is subject to periodic review and amendment.

(3) Step Therapy. Step therapy protocol means that a Covered Person may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Covered Persons access high quality yet cost effective Prescription Drugs. If a Provider decides that the monitored medication is needed the Precertification process is applied.

(4) Participating Specialty Pharmacy. The PBM's Specialty Pharmacy is available to Covered Persons who use Specialty Drugs.

(a) "Specialty Drugs" are Prescription Legend Drugs that are one of the following:

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

(b) Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, subject to a day supply limit for retail and mail service, and the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

(c) Questions regarding Specialty Drugs can be directed to the Customer Service telephone number on the back of your Identification Card.

(d) You may obtain a list of the Participating Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your Identification Card, or review the lists on our website at [insert address].

(5) Covered Services include the following.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Self-administered contraceptives, including oral contraceptives, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the Preventive Care section, please see that section for more details.
- Selected drugs to eliminate or reduce dependence on, or addiction to tobacco and tobacco products.
- Injectables.
- Selected preventive medications are covered with no Copayment or Coinsurance if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations. These medications include the following: vitamin D supplementation, folic acid supplementation, aspirin and oral fluoride supplementation.

(6) In addition to the Exclusions set forth in Article 4, Non-Covered Services include the following.

- Prescription Drugs dispensed by any mail service program other than the PBM's mail service pharmacy, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription.
- Drugs not approved by the FDA except as otherwise prohibited by law.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a physician. This does not apply to drugs used in conjunction with a Diagnostic Service, with chemotherapy performed in the office or drugs eligible for coverage under the Medical Supplies benefit.
- Any drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by this Contract, or which exceed any age limits established by us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility drugs.
- Human growth hormone for children born small for gestational age.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact us for additional information on these Prescription Legend Drugs.
- Refills of lost or stolen medications.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, unless otherwise required by law or approved by us. "Clinically equivalent" means drugs that, for the majority of persons, can be expected to produce similar therapeutic outcomes for a disease or condition.

(7) If you have questions regarding whether a particular Prescription Drug is covered and which Tier a Prescription Drugs fall into, please call the Customer Service telephone number on the back of your Identification Card, or visit our website at [website address].

(8) Each Prescription Drug may be subject to a Deductible, Coinsurance or Copayment. If the prescription includes more than one covered Prescription Drug, a separate Coinsurance or Copayment will apply to each covered

Prescription Drug. Your Copayment will be the lesser of your scheduled Copayment or the Allowable Amount.

(9) The number of days' supply of a Prescription Drug which you may receive is limited. The days' supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days' supply allowed for under this Contract, you should ask your Pharmacist to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

(10) Your Copayment or Coinsurance amount may vary based on whether the Prescription Drug has been classified by us as a first, second, third, fourth or fifth "Tier" Prescription Drug. The determination of Tiers is made by us based upon clinical information, and where appropriate the cost of the Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

(a) Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This Tier will contain low cost and preferred generic medications as well as selected preventive medications that are covered with no Coinsurance or Copayment if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations.

(b) Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This Tier will contain non-preferred generic medications.

(c) Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This Tier will contain preferred brand name medications.

(d) Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This Tier will contain non-preferred brand name medications.

(e) Tier 5 Prescription Drugs will have a higher/comparative Coinsurance or Copayment than those in Tier 4. This Tier will contain medications that are considered Specialty Drugs.

We have established a Pharmacy and Therapeutics Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Precertification criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives. The Pharmacy and Therapeutics Committee also determines, where appropriate, the cost of a

Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one drug over another in our patient program, and, where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

(11) From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, generic, mail service, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Prescription Drugs or preferred products for a limited period of time.

(12) The amount of Benefits paid is based upon whether you receive the Covered Services from a Participating Pharmacy, including a Participating Specialty Pharmacy, a Non-Participating Pharmacy, or the PBM's mail service program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug.

(13) How you obtain your Benefits depends upon whether you go to a Participating or a Non-Participating Pharmacy.

(a) Participating Pharmacy – Present your written prescription from your physician and your Identification Card to the pharmacist at a Participating Pharmacy. The Participating Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment or Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge and you believe the Prescription Drug should be covered, ask your pharmacist for an itemized receipt and submit it to us for reimbursement consideration.

(b) Specialty Drugs - You or your Provider can order your Specialty Drugs directly from a Participating Specialty Pharmacy, simply call the Customer Service telephone number on the back of your Identification Card. Your Specialty Drug may need Precertification prior to dispensing. Upon approval, your Specialty Drug will be delivered to your physician's office/your specified delivery location based on the physician's order. A clinician will be available to answer any questions you may have in regard to the Specialty Drug and the instructions.

(c) Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy, including a Non-Participating Specialty Pharmacy. You must submit a claim for reimbursement consideration as set forth in Article 8 Section C.

(d) The Mail Service Program – Complete the order and patient profile form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have your physician fax the prescription to the mail service pharmacy. Your physician may also phone in the prescription to the mail service pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the mail service pharmacy when you request a prescription.

(14) Drug Exception Program. This is a program designed to allow Covered Persons to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. The Drug Exception Program is separate from and in addition to the benefit review and appeals processes outlined in Article 7. Please call the Customer Service number on the back of your Identification Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary.

Y. Pediatric Vision Services. The following Health Care Services are Covered Services only for Covered Person through the age of nineteen (19). The Contract only provides Benefits for vision care that is listed in this section.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A complete pediatric eye exam. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together. The exam may include the following.

- Case History.
- Cover test.
- Ocular Motility.
- Neurological Integrity.
- External Exam.
- Internal Exam.
- Retinoscopy.
- Phorometry testing.
- Point refraction.
- Tonometry.
- Opthalmoscopic exam.
- Confrontation Visual Fields.
- Biomicroscopy.
- Color Vision Testing.
- Diagnosis/Prognosis.
- Recommendations.

(2) Eyeglass Lenses. Lens options include a choice of plastic or polycarbonate. Lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include up to 55 mm in single vision, bifocal, trifocal or lenticular.

(3) Frames. This Contract offers a selection of frames that are covered.

(4) Contact Lenses. Coverage includes the following.

(a) Contact Lens professional fitting fees.

(b) Elective Contact Lenses (elective contact lenses are contacts that are chosen for comfort or appearance).

(c) Non-Elective Contact Lenses are only provided for the following medical conditions.

- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when the patient's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

(d) Medically Necessary contact lenses are available in lieu of ophthalmic lenses and may be subject to Copayments, Coinsurance and limitations. The Provider determines a patient's qualifying criteria at examination and evaluation, and will obtain any necessary Precertification from us for these services.

(5) Low Vision Benefits

(a) Comprehensive Low Vision Exam.

(b) Optical/Non-optical aids.

(c) Supplemental testing.

(6) Non-Covered Services include services incurred for, or in connection with, any of the items below.

- Non-elective contact lenses for any Covered Person who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- For safety glasses and accompanying frames.
- For Inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Covered Person has reached the normal interval for service when seeking replacements.

- For services or supplies not specifically listed in this Contract.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Vision services for Covered Persons over the age of nineteen (19) unless specifically stated in this Contract.

ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS

E. **Non-Covered Services**. This Article 5 sets forth services that are excluded from coverage under this Contract and therefore are Non-Covered Services. Non-Covered Services are not covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

F. **Exclusions**. The following are Non-Covered Services:

(1) Services that we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.

(2) Services received from an individual or entity that is not a Provider.

(3) Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.

(4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

(5) Services provided as benefits by any governmental unit, unless otherwise required by law or regulation.

(6) Services for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

(7) Services for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

(8) Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

(9) Court ordered testing or care unless Medically Necessary.

(10) Services for which you have no legal obligation to pay in the absence of this or like coverage.

(11) Charges for consulting with Covered Persons by telephone, facsimile, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Covered Person except as otherwise described in this Contract.

(12) Surcharges for furnishing and/or receiving medical records and reports.

(13) Charges for doing research with Providers not directly responsible for your care.

(14) Charges that are not documented in Provider records.

(15) Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.

(16) Administrative or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

(18) Services prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

(19) Completion of claim forms or charges for medical records or reports unless otherwise required by law.

(20) Missed or canceled appointments.

(21) Mileage, lodging and meals costs, and other travel related expenses, except as authorized by us or specifically stated as a Covered Service in this Contract.

(22) Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.

(23) Services incurred prior to the Effective Date.

(24) Services incurred after the termination date of this coverage except as specified elsewhere in this Contract.

(25) For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Complications directly related to Cosmetic Services treatment or surgery, as determined by us, are not covered. This exclusion applies even if the original Cosmetic Services treatment or surgery was performed while the Covered Person was covered by another carrier/self-funded plan prior to coverage under this Contract. “Directly related” means that the treatment or surgery occurred as a direct result of the Cosmetic Services treatment or surgery and would not have taken place in the absence of the

Cosmetic Services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

(26) Maintenance Therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance Therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

(27) Custodial Care, convalescent care or rest cures.

(28) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

(29) Services provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

(30) Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

(31) Services or care provided or billed by a school, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(32) Wilderness camps.

(33) For routine foot care (including the cutting or removal of corns and calluses), Nail trimming, cutting or debriding, Hygienic and preventive maintenance foot care, including but not limited to 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.

(34) Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

(35) Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to the following.

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

(36) 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.

(37) Dental implants.

(38) Dental braces.

(39) Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following.

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer or cleft palate.

(40) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

(41) Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

(42) Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by us, are not covered. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(43) Marital counseling.

(44) Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

(45) Vision orthotic training.

(46) Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.

(47) Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

(48) Services to reverse voluntarily induced sterility.

(49) Diagnostic testing or treatment related to infertility.

(50) Personal hygiene, environmental control, or convenience items including but not limited to the following.

- Air conditioners, humidifiers, air purifiers.
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals.
- Charges for non-medical self-care except as otherwise stated.
- Purchase or rental of supplies for common household use, such as water purifiers.
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds.
- Infant helmets to treat positional plagiocephaly.
- Safety helmets for Covered Persons with neuromuscular diseases.
- Sports helmets.

(51) Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

(52) Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by us, or as otherwise described in this Contract.

(53) Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.

(54) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

(55) For self-help training and other forms of non-medical self-care, except as otherwise provided in this Contract.

(56) Examinations relating to research screenings.

(57) Stand-by charges of a Provider.

(58) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

(59) Services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

(60) Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Contract.

(61) Manipulation Therapy services rendered in the home as part of Home Care Services.

(62) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. This Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

(63) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

(64) Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

(65) Any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(66) Surgical treatment of gynecomastia.

(67) Treatment of hyperhidrosis (excessive sweating).

(68) Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by us through Precertification.

(69) Complications directly related to a service or treatment that is a Non-Covered Service under this Contract because it was determined by us to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

(70) Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

(71) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

(72) Treatment of telangiectatic dermal veins (spider veins) by any method.

(73) Reconstructive services except as specifically stated in this Contract or as required by law.

(74) Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

(75) For non-preventive medical nutritional therapy.

(76) Abortions that are not Therapeutic Abortions.

G. Experimental/Investigative Health Care Services Exclusion. We do not provide coverage for any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be Experimental/ Investigative.

(1) 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.

(a) 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 granted.

(b) Has been determined by the FDA to be contraindicated for the specific use.

(c) Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

(e) 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.

(2) Any Health Care Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by us. In determining whether a Health Care Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

(a) The scientific evidence is conclusory concerning the effect of the Health Care Service on health outcomes.

(b) The evidence demonstrates the Health Care Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects.

(c) The evidence demonstrates the Health Care Service has been shown to be as beneficial for the total population for whom the Health Care Service might be proposed as any established alternatives.

(d) The evidence demonstrates the Health Care Service has been shown to improve the net health outcomes of the total population for whom the Health Care Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(3) Off-Label Drug Treatment. Coverage for a drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

(a) The drug is recognized for treatment of the indication in at least one standard reference compendium.

(b) The drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have

been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the drug's use to be contraindicated or the drug has not been approved by the FDA for any indication.

(4) The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

(a) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.

(b) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.

(c) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Documents of an IRB or other similar body performing substantially the same function.

(e) Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(f) Medical records.

(g) The opinions of consulting Providers and other experts in the field.

ARTICLE 6. OBTAINING COVERED SERVICES

E. Participating Providers.

(1) Unless otherwise specifically provided in this Contract, in order to receive Benefits under this Contract, a Covered Person must receive Covered Services from a Participating Provider.

(2) The Covered Person is responsible for verifying that a Provider is a Participating Provider. A list of Participating Providers is available online at [insert website] or by calling us at [toll free number].

F. Non-Participating Providers. Health Care Services received from Non-Participating Providers are Non-Covered Services except for the following circumstances.

(1) Emergency Health Care Services.

(a) If we determine that the Health Care Services were not an Emergency, the Health Care Services are Non-Covered Services and you will be responsible for costs associated with the Health Care Services.

(b) Subsequent follow up care by a Non-Participating Provider after the condition is no longer an Emergency is a Non-Covered Service unless specifically authorized by us.

(c) If a Covered Person is hospitalized in a Non-Participating Hospital due to an Emergency, you or the Provider must notify us within 48 hours of the admission. A continued stay after the condition is stabilized and is no longer an Emergency requires our written authorization. We may elect to transfer the Covered Person to a Participating Hospital once it is medically appropriate to do so.

(2) Non-emergency Medically Necessary Health Care Services that cannot be provided by a Participating Provider and for which the Covered Person has obtained a Referral from his/her Primary Care Physician.

(3) Maternity services for a Covered Person who was in her second or third trimester of pregnancy as of her Effective Date as provided in Article 3 Section K.

(4) When our agreement with a Participating Provider terminates, upon your written request, the Covered Person may continue to receive Covered Services from the Provider for the following time periods.

(a) Up to sixty (60) days.

(b) In the case of Covered Person who is pregnant and in the third trimester of pregnancy, you may continue to receive Covered Services through the term of the pregnancy.

(c) For a Covered Person who is hospitalized until the Covered Person is discharged from Inpatient status.

G. Primary Care Physician.

(1) You must designate a Primary Care Physician for each Covered Person. If you do not select a Primary Care Physician we will assign one.

(2) The Covered Person's Primary Care Physician will be responsible for coordinating Covered Services and making referrals to other Participating Providers. A Covered Person does not need a referral from his/her Primary Care Physician for obstetrical or gynecological treatment from a Participating Provider. A Covered Person may seek care directly from an obstetrician or gynecologist that is a Participating Provider. For all other Providers, the Covered Person must obtain a referral from his/her Primary Care Physician to obtain benefits for Covered Services under this Contract.

(3) You may change the selection of a Primary care Physician no more frequently than once each month. A Covered Person may change his/her Primary Care Physician by submitting a written request, online at [insert website address], or by contacting us at the number shown on your Identification Card. A change in Primary Care Physician selection will be effective no later than thirty (30) days from the date we receive a request.

ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES.

This Article 7 sets forth the procedures for requesting approvals for Covered Services from us as well as the ***claim review procedures for benefit determinations adverse to the Covered Person***. In processing claims, we review requests for Precertification, Predetermination, and Post Service Clinical Claims Review to determine whether provided or proposed to be provided Health Care Services are Covered Services. Health Care Services must be Medically Necessary for Health Care Services to be considered Covered Services.

A. Covered Service Review Requests

(1) Types of Covered Service Review Requests.

(a) Precertification – 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.

(b) Predetermination – An optional, voluntary prior or concurrent request for a benefit coverage determination for a Health Care Service. We will review this Contract to determine if there is an Exclusion for the service or treatment requested. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service or treatment meets our definition of Medical Necessity, or if it is Experimental/Investigative as that term is defined in this Contract.

(c) Post Service Clinical Claims Review – A retrospective review (Post-Service) for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Precertification and did not undergo a Predetermination review. Post Service Clinical Claims Reviews are done for Health Care Services for which we have a related clinical coverage guideline and are typically initiated by us.

(2) Most Participating Providers know which Health Care Services require Precertification and will get Precertification or ask for Predetermination from us as needed. The Covered Person's Primary Care Physician and all other Participating Providers have received information from us on the procedures for requesting approvals for Covered Services and are responsible for meeting the requirements under such procedures. Generally, the Participating Provider ordering the service, treatment or admission will contact us to ask for Precertification or Predetermination reviews ("Requesting Provider"). We will work directly with the Requesting Provider regarding such review requests; however, the Covered Person's Designated Representative may act on the Covered Person's behalf throughout the review process.

(3) We will utilize our clinical coverage guidelines, including internally developed guidelines, procedures, and preventative care clinical coverage guidelines, to help us determine whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions Identified

as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

(4) The Covered Person is entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact us at [toll free number].

B. Review Request Categories.

(1) Urgent Care – A request for Precertification or Predetermination that in the view of the attending Provider, or any physician with knowledge of the Covered Person's medical condition, could seriously jeopardize the Covered Person's life or health or the Covered Person's ability to regain maximum function, or would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Urgent Care Claim.

(2) Pre-Service – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

(3) Concurrent Care – A request for Precertification or Predetermination that is conducted during an ongoing course of treatment or admission. If we have approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by us of such course of treatment before the end of such period of time or number of treatments shall constitute a benefit determination adverse to the Covered Person. We will notify the Covered Person sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination before the benefit is reduced or terminated.

(4) Post-Service – A request for approval that is made after the service, treatment or admission has occurred. Post-Service review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

C. Benefit Decision and Notice Requirements.

(1) We will resolve benefit review requests according to the timeframes listed in the table below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws.

Request Categories	**Timeframe Requirement for Benefit Decisions and Notification**
Pre-Service Claim	15 calendar days from receipt of request
Pre-Service Urgent Care Claim	72 hours from receipt of request

Concurrent Care Claim	15 calendar days from receipt of request
Concurrent Urgent Care Claim	24 hours from receipt of request
Post-Service Claim	20 business days from receipt of request

D. Timeframe Extensions for Benefit Decisions and Notifications.

(1) Post-Service and Pre-Service Claims. If we are unable to complete our review due to circumstances beyond our control, we will notify the Covered Person, the Covered Person's Designated Representative, and the Requesting Provider in writing within:

(a) Fourteen (14) days after our receipt of a Pre-Service claim review request, and

(b) Nineteen (19) days after our receipt of a Post-Service claim review request.

The written notice will include the reason for the delay, a list of any applicable additional information that we need from the Covered Person in order to complete our review and a revised timeframe for the resolution. If the reason for the delay is because the Covered Person's review request lacked sufficient information to complete our review of the Covered Person's request, the Covered Person, the Covered Person's Designated Representative and Requesting Provider will have forty-five (45) days from receiving our notice of delay to provide the necessary information. We will notify the Covered Person, the Covered Person's Designated Representative and the Requesting Provider of our decision within not more than ten (10) days after notifying the Covered Person, the Covered Person's Designated Representative and Requesting Provider of the reason for our delay or of our receipt of the necessary information or of the end of the period afforded to the Covered Person to supply the necessary information, as applicable. If we do not get the specific information we need or if the information is not complete by the timeframe provided to the Covered Person, we will make a decision based upon the information we have.

(2) Urgent Care Claims. If the Covered Person fails to provide us with sufficient information to review the Covered Person's Urgent Care Claim review request, we will notify the Covered Person as soon as possible, but not later than twenty-four (24) hours after our receipt of the claim, of the specific information necessary to complete our review. The Covered Person will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. We will notify the Covered Person, the Covered Person's Designated Representative and Requesting Provider of our decision as soon as possible, but in no case later than forty-eight (48) hours of the earlier of the following:

(a) our receipt of the necessary information, or

(b) the end of the period afforded to the Covered Person to supply the necessary information.

If we do not get the specific information we need or if the information is not complete by the timeframe provided to the Covered Person, we will make a decision based upon the information we have.

E. Denial of Experimental Treatment.

If we deny coverage for a treatment, procedure, drug or device on the grounds that the treatment, procedure, drug or device is experimental, we will provide the Covered Person with a written explanation that includes the following information:

(a) The basis for the denial.

(b) The Covered Person's right to Appeal our decision.

(c) Our telephone number that the Covered Person may contact for assistance in initiating an Appeal of our decision.

(2) If the Covered Person's health situation is life threatening or is an emergency, the Covered Person is entitled to a review of our decision to deny coverage on the grounds that the treatment, procedure, drug or device is experimental that takes not more than seventy-two (72) hours.

F. Benefit Decision Appeals

(3) Right to Appeal. If the Covered Person or the Covered Person's Requesting Provider disagrees with our decision regarding the Covered Person's benefit review request the Covered Person or the Covered Person's Designated Representative may initiate an Appeal by contacting us either in writing and/or by phone at the address and phone number provided below.

[Address]

The Covered Person's Appeal must be initiated within 180 days of receiving our decision regarding the Covered Person's benefit review request. We will acknowledge your Appeal within 3 business days of our receipt of the Appeal Request.

(4) Appeal Panel. We will appoint a panel of qualified individuals to resolve the Appeal (the "Appeal Panel"). We will ensure that no individual is appointed to the Appeal Panel who was involved in the matter giving rise to the compliant or in the initial investigation of the complaint.

(a) If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:

(a) Has knowledge in the medical condition and Health Care Service;

(b) Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and

(c) Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with the Covered Person or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.

(b) The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date and place during normal business hours for the Appeal Panel to meet to discuss the Appeal. The Covered Person will be given seventy-two (72) hours advance notice of the date and time of the meeting. The Covered Person or the Covered Person's Designated Representative may appear in person at the Appeal Panel meeting or communicate with the Appeal Panel through appropriate other means if the Covered Person or the Covered Person's Designated Representative are unable to appear in person.

(5) Timeframe for Resolution of Appeals. The Appeal Panel will resolve Appeals according to the timeframes listed in the table below.

Appeal Categories	**Timeframe Requirement for Appeal Decisions and Notification**
Appeal of a Pre-Service Claim Decision	30 calendar days from our receipt of the Appeal
Appeal of a Pre-Service Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Concurrent Care Claim Decision	15 calendar days from our receipt of the Appeal
Appeal of a Concurrent Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Post-Service Claim Decision	45 calendar days from our receipt of the Appeal

We shall notify the Covered Person or the Covered Person's Designated Representative of our decision in writing regarding the Appeal within five (5) business days after we complete our investigation.

(6) Expedited Review of Internal Appeals.

(a) An Expedited Review of an internal Appeal may be initiated orally, in writing or by other reasonable means available to the Covered Person, the Covered Person's Designated Representative or the Covered Person's Provider.

(b) Expedited Review is available only if the Covered Person's attending Provider believes that, based upon the Covered Person's medical condition, our standard internal Appeal procedure could seriously jeopardize the Covered Person's life or health or the Covered Person's ability to regain maximum function, or could subject the Covered Person to severe pain that cannot be adequately managed.

(c) Appeals of Urgent Care Claim decisions are referred directly to our Expedited Review procedure for investigation and resolution.

(d) We will complete our Expedited Review of the Appeal as soon as possible given the medical exigencies but no later than within 72 hours after our receipt of the Covered Person request for Appeal.

(e) We will communicate our decision regarding the Appeal by telephone to the Covered Person, the Covered Person's Designated Representative, and the Covered Person's attending Provider. We will also provide written notice of our decision to the Covered Person, the Covered Person's Designated Representative and the Covered Person's attending Provider.

(f) An Expedited Review of Concurrent Urgent Care Claims and Pre-Service Urgent Care Claims may occur at the same time as an External Review (as described below).

G. External Review

(1) The Covered Person or the Covered Person's Designated Representative may seek External Review if our decision regarding the Appeal upheld a decision that was adverse to you regarding any of the following.

(a) A Medically Necessary service.

(b) A utilization review decision.

(c) A determination that a proposed service is Experimental/Investigational.

(d) A decision to rescind the Covered Person's Contract.

If the Covered Person's Appeal did not involve one of the above adverse decisions, the Covered Person is not entitled to an External Review.

(2) If the Covered Person has the right to an External Review under Medicare (42 U.S.C. 1395, et seq.) the Covered Person may not request an External Review of our Appeals decision under the procedures outlined in this Contract.

(3) If the Covered Person's situation qualifies, the Covered Person or the Covered Person's Designated Representative must file a written request for an External Review with us within 120 days after the Covered Person receives notice of our internal response to the Appeal.

(4) Independent Review Organization (IRO).

(a) If an External Review is requested, we will forward all information related to the Covered Person's External Review to an IRO selected from the list of IROs that are certified by the Indiana Department of Insurance.

(b) The IRO will make a determination to uphold or reverse our Appeal decision within seventy-two (72) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within fifteen (15) business days if the condition does not involve an Urgent Care Claim.

(c) The IRO will notify the Covered Person and the Covered Person's Designated Representative of its decision within twenty-four (24) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within seventy-two (72) hours if the review does not involve an Urgent Care Claim.

(d) If the IRO decision reverses our Appeals decision, we will notify the Covered Person, the Covered Person's Designated Representative or Provider in writing of the steps we will take to comply with the Iron's decision.

H. Important Contact Information and Notice to Covered Persons

(1) Questions regarding the Covered Person's coverage should be directed to: [Indiana University Health Plans]; [toll free number]

(2) If the Covered Person (a) needs the assistance of the governmental agency that regulates insurance; or (b) has a complaint the Covered Person has been unable to resolve with us the Covered Person may contact the Department of Insurance by mail, telephone or email:

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

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

Complaints can also be filed electronically at www.in.gov/Idoi.

ARTICLE 8. PAYMENT FOR COVERED SERVICES

A. How to Obtain Benefits.

(1) Whenever the Covered Person receives Health Care Services, the Covered Person must provide the Provider with a copy of the Covered Person's Identification Card.

(2) When the Covered Person receives Covered Services from a Participating Provider you are not required to file a claim. Since no claim filing is required, you are not required to follow the procedures outlined in Section C of this Article 8.

B. Who Receives Payment Under This Contract.

(1) We pay Benefits for the Covered Person's Covered Services directly to a Participating Provider.

(2) If the Covered Person receives Covered Services from a Non-Participating Provider as provided in Article 6 Section B, we will pay Benefits to the Non-Participating Provider, unless you agreed to make payment to the Non-Participating Provider and are entitled to reimbursement for such payment.

C. Payment for Covered Services received from Non-Participating Providers.

(1) Time to File Claims. For Covered Services received from a Non-Participating Provider, written notice of a claim must be given to us, by you or the Non-Participating Provider, within thirty (30) days of the date the Covered Services began. Failure to furnish the claim within thirty (30) days will not invalidate or reduce any claim if submission within thirty (30) days was not reasonably possible, so long as the claim is submitted within a reasonable time.

(2) Claim Forms. We shall provide forms to you for filing Proof of Loss within fifteen (15) days of notice of any claim. If you do not receive the forms within fifteen (15) days, written notice of services rendered may be submitted to us without the claim form. Claim forms are available on our website at [website address].

(3) Proof of Loss. Proof of loss under this Contract must be furnished to us within ninety (90) days after the loss. Failure to furnish the claim within ninety (90) days will not invalidate or reduce any claim if submission within ninety (90) days after the loss was not reasonably possible, so long as the claim is submitted within one (1) year after the time required under this Contract unless you were legally incapacitated.

(4) Address. All correspondence regarding claims should be sent to us at:

[Indiana University Health Plans]
[Address]
[City/state/zip]
[Fax]

(5) Amount of Payment. Payment for Health Care Services received from a Non-Participating Provider will be the lesser of the following amounts.

(a) The usual, customary and reasonable charge for the Health Care Service;

(b) An amount agreed upon by us and the Non-Participating Provider.

D. Clean Claims.

(1) A clean claim is a claim submitted by a Provider for payment that has no defect. We shall pay or deny each clean claim as follows.

(a) If the claim is filed electronically, within thirty (30) days after the date we receive the claim.

(b) If the claim is filed on paper, within forty-five (45) days after the date we receive the claim.

(2) If we fail to pay or deny a clean claim in the time frames set forth above and subsequently pay the claim, we will pay the Provider that submitted the claim allowable interest in accordance with Indiana Code § 27-8-5.7-6.

ARTICLE 9. COORDINATION OF BENEFITS

This Article applies only if you also have other health benefits coverage with another Plan. The Definitions contained in this Article apply throughout this Article 9 but do not apply to the rest of the Contract.

A. **When you have other health benefits**. In the event that you are covered by two health insurance contracts, plans or policies ("Plans") providing similar benefits and you receive a Health Care Service that would be covered by both Plans, we will coordinate benefit payments with any payment made under the other Plan. One company will pay its full benefit as the Primary Plan. The other company will pay Secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments.

B. **Definitions**.

(1) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the Plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(2) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

(3) "Closed Panel Plan" means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in the case of emergency or referral by a panel Covered Person.

(4) "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(5) "Plan" means any of the following that provides benefits or services for medical treatment:

(a) Any group or blanket insurance contract, plan or contract, except that blanket school accident coverage or such coverage offered to

substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or contract.

(b) Any self-insured or noninsured Plan or any other Plan arranged through an employer, trustee, union, employer organization or employee benefit organization.

(c) Any coverage under governmental programs or any coverage required to be provided by any statute. However, Medicaid and any Plan whose benefits are, by law, excess to those of any private insurance plan or other nongovernmental plan shall not be considered health insurance policies.

(d) Group or nongroup coverage through Closed Panel Plans or group type contracts.

(e) Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional "fault" type contracts.

(6) "Primary" or "Primary Plan" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If the Plan is Primary to another Plan, the Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(7) "Secondary" or "Secondary Plan" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If the Plan is Secondary to another Plan, the Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

C. Rules To Determine Payment. When two or more Plans pay benefits, the rules for determining the order of payments are as follows:

(1) The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

(2) If the other Plan does not have a provision similar to this one, then it will be primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(3) A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. Order of Determination of Benefits Rules: The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent is Primary, for example as an employee, subscriber or retiree is

primary and the Plan that covers the person as a Dependent is Secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent; then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, subscriber or retiree is Secondary and the other Plan is Primary.

(2) Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods commencing after the Plan is given notice of the court decree.

(d) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(a) The Plan of the Custodial Parent.

(b) The Plan of the spouse of the Custodial Parent.

(c) The Plan of the non-Custodial Parent.

(d) The Plan of the spouse of the non-Custodial Parent.

(3) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is Primary. The same would hold true is a person is a Dependent of a person covered as a retiree or an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined Section (C)(1) of this Article 9.

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, subscriber or retiree (or as that person's Dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, subscriber or retiree longer is Primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid if it had been Primary.

E. Payment of the Benefit When This Plan is Secondary.

(1) When this Plan is Secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other Plan and this Plan do not exceed your expenses for an item of service. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by the Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

(a) Determine its obligation to pay or provide benefits under its Plan;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

(2) If there is a benefit reserve, the Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

(3) If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, Coordination of Benefits shall not apply between that Plan and other Closed Panel Plans.

F. Payments to others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid.

G. Our Right to Recover Overpayment. In some cases, we may have made payment even though you had coverage under another Plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the

payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other Plan. You agree to sign any document that we deem necessary to help us recover any overpayment.

ARTICLE 10. TERMINATION OF COVERAGE

A. [**Guaranteed Renewable.** As long as a Covered Person continues to be a Qualified Individual and this Contract continues to be a Qualified Health Plan, you may renew this Contract at your option without regard to the health status of you or any Covered Person.]

[Guaranteed Renewable. Coverage under this Contract is guaranteed renewable at the discretion of the Subscriber, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, as described in this Article 10. The Subscriber may renew this Contract at the Subscriber's option without regard to the health status of you or any Covered Person. You may renew this Contract by payment of the renewal premium by the end of the Grace Period of the premium due date, provided the following requirements are satisfied:

(1) Eligibility criteria outlined in Article 2 continues to be met.

(2) There are no fraudulent or intentional misrepresentations on the application or under the terms of this Contract.

(3) Coverage has not been terminated by us under the terms of this Contract.]

B. **Termination.** We may terminate this Contract or coverage of a Covered Person for the following reasons.

(1) The Covered Person is no longer eligible for coverage [through the Indiana Marketplace].

(2) A Covered Person is no longer eligible under [the rules of the Indiana Marketplace or] the terms of this Contract.

(3) You do not pay premium and the applicable Grace Period has been exhausted.

(4) We receive a request from you to terminate the Contract.

(5) You or a Covered Person commits an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact.

(6) A Covered Person changes coverage to another [Qualified Health Plan] [health plan] during the [Indiana Marketplace] Open Enrollment Period or a Special Enrollment Period.

(7) [The Contract is no longer a Qualified Health Plan or we are decertified by the Indiana Marketplace.]

(8) You no longer reside in our Service Area.

(9) We discontinue a particular product provided that we provide you with written notice at least ninety (90) days before the date the product will be discontinued, we offer you the option to purchase any other individual contract we currently offer, and we act uniformly without regard to any health status-related factor.

(10) We discontinue all contracts in the individual market in Indiana provided that we provide you and the Indiana Department of Insurance with written notice at least 180 days before the date of the discontinuance, we discontinue and do not renew all contracts in the individual market in the State of Indiana, and we act uniformly without regard to any health status-related factor.

(11) We may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with the laws of the State of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

C. Effective Date of Termination. [Termination of this Contract automatically terminates all coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if this Contract is in effect at the time such services are provided.]

(1) If you terminate this Contract or coverage for a Covered Person, the last day of coverage [will be on the last day of the billing period for which premium has been paid. A request for termination must be received by us in writing] [is:

(a) The termination date specified by you, if reasonable notice is provided;

(b) If you do not provide reasonable notice, fourteen (14) days after the termination is requested, or

(c) If you do not provide reasonable notice and request a termination date in less than fourteen (14) days, on a date determined by us if we are able to implement termination in fewer than fourteen (14) days.]

(2) [If newly eligible for Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.]

(3) [If all Covered Persons are no longer eligible for coverage through the Indiana Marketplace, the last day of coverage is the last day of the month following the date notice is sent to us by the Indiana Marketplace, unless you request an earlier termination effective date.] [If you move outside of the Service Area, the last day of coverage for you and all of your Dependents will be at the end of the billing period that contains the date you no longer resided in the Service Area.]

(4) [If a Covered Person is no longer eligible for coverage under the rules of the Indiana Marketplace or the terms of this Contact, the last day of coverage is the last day of the month following the date the Covered Person loses eligibility.] [If a Dependent no longer meets the definition of Dependent, the last day of coverage for the Dependent will be on the last day of the billing period in which we received notice of the Dependents loss of eligibility.]

(5) In the case of a termination for non-payment of premium and the applicable Grace Period has been exhausted, the last day of coverage [for all Covered

Persons] will [be either the last day of the first month of the 3-month Grace Period or] the last day for which premium was paid.

(6) [In the case of a termination due to a change to another Qualified Health Plan, the last day of coverage is the day before the effective date of coverage in his or her new Qualified Health Plan.]

D. Notice of Termination.

(1) We shall provide you with written notice of our intent to terminate or not renew this Contract at least sixty (60) days prior to the effective date of the termination. This notice will identify the date upon which your coverage will terminate.

(2) Our notice to the Subscriber shall be deemed as notice to all Covered Persons and is sufficient if mailed to the Subscriber's address as it appears in our records.

(3) Termination of this Contract shall not prejudice any claim for Covered Services rendered before the effective date of the termination.

E. Continuation of Coverage.

(1) If we terminate this Contract, except for a termination due to our receivership, and a Covered Person is hospitalized for a medical or surgical condition on the effective date of the termination, coverage will continue for Inpatient Covered Services. Benefits shall end on the earliest of the following dates.

(a) The date the Covered Person is discharged from the Hospital.

(b) The date the Covered Person is covered under other health coverage if that coverage covers the Inpatient Hospital services.

(c) Sixty (60) days after the date this Contract ends.

(d) The last day the required premium has been paid if the Grace Period expires and the Subscriber has not made the required payment.

(e) The date the you terminate coverage.

(2) If this Contract terminates due to our receivership, coverage will continue for the following time period:

(a) The duration of the contract period for which premiums have been paid.

(b) If a Covered Person is hospitalized on the date of our receivership for the longer of the following time periods.

(A) The period ending when the Covered Person is discharged from the Inpatient hospitalization.

(B) The duration of the contract period for which premiums have been paid.

F. **Rescission.** If within two (2) years after the Effective Date of this Contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that the Subscriber or a Covered Person did not disclose on the application, we may rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding your newly born children within 31 days of birth), we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that the Subscriber or a Covered Person did not disclose on the application, we may rescind coverage for the additional Dependent as of his or her original Effective Date. Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by the Subscriber or a Covered Person may result in termination or rescission of coverage. The Subscriber is responsible to pay us for the cost of previously received services based on the Allowed Amount for such services, less any Copayments/Coinsurance paid or Premium paid for such services.

This Contract may also be terminated if the Subscriber or a Covered Person knowingly participates in or permit fraud of deception by any Provider, vendor or any other person associated with this Contract. Termination for any act, practice or omission that constituted fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give the Subscriber at least thirty (30) days written notice prior to the rescission of this Contract.

G. **Reinstatement.** If this Contract was terminated for non-payment of premium, you may request reinstatement of the Contract from [the Indiana Marketplace] [us] within 30 days of the effective date of the termination. You must remit all premium that was due for the coverage upon reinstatement. Upon [notice from the Indiana Marketplace and] receipt of the outstanding premium, we will reinstate coverage as of the effective date of the termination.

H. [**Certification of Prior Creditable Coverage If Required by Law.** If this coverage is terminated, all Covered Persons will receive certification from us showing that they were covered under this Contract. A Covered Person may need this certification document in order to purchase other health coverage. Certifications may be requested within twenty-four (24) months of losing coverage.

A Covered Person may also request certification be provided to he or she at any other time, even if he or she has not lost your coverage under this Contract. If a Covered Person has any other questions regarding certification of creditable coverage, contact the Customer Service telephone number on the back of your Identification Card.]

ARTICLE 11. GRIEVANCE PROCEDURES

The Grievance procedures provided in this Article 11 are established and maintained by us for the filing, investigating, and resolving of Grievances and Appeals that are ***unrelated to benefit decisions*** that are adverse to you. ***For procedures applicable to benefit decisions please refer to Article 7 of this Contract.***

E. **What is a Grievance**. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(1) Availability, delivery, appropriateness, or quality of health care services.

(2) Handling or payment of claims for health care services.

(3) Matters pertaining to the contractual relationship between you and us.

F. **Who May File.**

(1) You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

(2) If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

G. **How a Grievance May Be Filed.**

(1) You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, including fax]

(2) A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

H. **No Retaliation**. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 10 or Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 10 or Article 7.

I. **Grievance Procedure**.

(1) Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in

writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

(2) Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

(3) Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

(4) Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

(5) Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

J. Appeals Procedure.

(1) Right to an Appeal.

(a) If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

(b) You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

(c) The Appeal may be expressed orally or in writing.

(d) We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

(2) Appeal Panel.

(a) Our Appeal Panel (the "Appeal Panel") will resolve the Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

(b) You or Your Designated Representative may:

(a) appear in person before the Appeal Panel; or

(b) communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

(c) You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

(d) To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

(e) The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

(3) Appeal Decision and Notice of Decision.

(a) The Appeal Panel's decision regarding Your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

(b) We will notify you in writing of the Appeal Panel's decision within five (5) business days after it is decided.

K. Notice to Covered Persons.

(1) If you have questions regarding your rights under this Contract or if you need Assistance, please contact us at:

[Indiana University Health Plans]
[toll free number]

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

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

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

Complaints can be filed electronically at www.in.gov/Idoi.

(3) The review procedures described in this Article 11 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

ARTICLE 12. GENERAL PROVISIONS

A. **Entire Contract**. This Contract, the Schedule of Benefits, and any application, rider or amendment(s) make up the entire agreement between you and us as of the Effective Date and supersede all other agreements. All statements made by you shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce coverage under this Contract or be used in defense of a legal action unless it is contained in the application.

B. **No Assignment**. The benefits provided under this Contract are for the personal benefit of all Covered Persons. You may not assign any of these rights to coverage. Any attempt by you to assign this Contract to any third party is void. Provided, however, that subject to our right to disapprove, you may assign your right to reimbursement for Covered Services to the Provider who provided such Covered Services.

C. **Notice**. Any notice that we give to you under this Contract will be mailed to your address as it appears on our records. Our notice to the Subscriber is deemed notice to all. Notice is deemed delivered three (3) calendar days after its deposit in the United State Mail with first class postage prepaid unless otherwise stated in this Contract. If you have to give us any notice, it should be mailed to:

[Indiana University Health Plans, Inc.]
950 North Meridian Street, Suite 200
Indianapolis, Indiana 46204

D. **Relationship Between Parties**. The relationships between us and Participating Providers are *solely* contractual relationships between a payor and independent contractors. Non-Participating Providers have no contractual relationship with us, nor are they our independent contractors. Providers are not our agents or employees. We and our employees are not employees or agents of Providers. The relationship between a Provider and any Covered Person is that of Provider and patient. The Provider is *solely* responsible for the services provided to any Covered Person.

E. **Disagreement with Recommended Treatment.** Each Covered Person enrolls in this Contract with the understanding that the Provider is responsible for determining the treatment appropriate for their care. The Covered Person may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate Health Care Services in a manner compatible with the Covered Person's wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice. If the Covered Person refuses to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, the Covered Person will be so advised. In such case, the Provider and we, as applicable, may determine that neither this Contract nor the Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of this Contract for the condition under treatment or any complications thereof.

F. **Your Medical Records**. As a condition precedent to the approval of claims hereunder, each Covered Person authorizes and directs any Provider that furnishes benefits hereunder to make available to us information relating to all Health Care Services, copies thereof and other records as needed by us for purposes of administering this Contract. In every case we will hold such information and records as confidential in accordance with state and federal confidentiality requirements.

G. **Second Opinion Policy**. A second opinion may be required at our discretion prior to the scheduling of certain Covered Services. We will advise you if a proposed Covered Service is subject to the second opinion policy. If so, you must consult with a second Participating Provider prior to the scheduling of the service. You must (a) contact us to obtain a list of Participating Providers who are authorized to render a second opinion, and (b) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider. You must obtain the second opinion within thirty-one (31) days of the first opinion or as soon thereafter as is reasonably possible. Second opinions we have arranged as described above are provided at no cost to you. A second opinion may also be obtained at the request of a Covered Person, subject to separate benefit restrictions and/or Copayments or Coinsurance described in this Contract.

H. **Who May Change This Contract**. This Contract may not be modified, amended or changed, except in writing, and signed by one of our officers. No employee, agent or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage or the conditions of eligibility, enrollment or participation unless in writing and signed by one of our officers. We are not bound by any verbal statements. We will provide the Subscriber with written notice of any material modification to this Contract not later than sixty (60) days prior to the date on which such material modification will become effective.

I. **Renewal Date**. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date for the term set forth in the Contract unless otherwise terminated by us as permitted by the Contract or by you upon thirty (30) days' prior written notice.

J. **Identification Cards**. Identification Cards are issued by us for identification only. Possession of any Identification Card confers no right to services or benefits under this Contract. To be entitled to such services or benefits the Covered Person's premiums must be paid in full at the time the Health Care Services are sought to be received. Coverage under this Contract may be terminated by us if the Covered Person allows another person to wrongfully use the Identification Cards.

K. **Right to Develop Guidelines and Administrative Rules**. We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Contract. An example of the use of the standards is to determine whether care was Medically Necessary. These standards will not be contrary to the descriptions in this Contract. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Contract.

L. **Non-Discrimination**. In compliance with state and federal law, we shall not discriminate on the basis of age; gender; color; race; disability; marital status; sexual preference; religious affiliation; or public assistance status. We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care. We shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew Coverage, (b) cancel coverage, (c) limit Benefits, or (d) charge a different premium. We shall not discriminate against victims of abuse in compliance with Indiana Code Sec. 27-8-24.3-1.

M. **Incontestability**. The validity of the Contract may not be contested after two (2) years, except for nonpayment of premiums or if the disputed statement is in a written instrument signed by the Subscriber. The ineligibility of Dependent under the Contract may be disputed at any time.

N. **Limitation of Action**. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Contract and within three (3) years from the date the Health Care Services were received. The Subscriber's damages shall be limited to recovery of actual Benefits due under the terms of this Contract. The Covered Person waives any right to recover any additional amounts or damages including, but not limited to, punitive and/or exemplary damages.

O. **Examination of Covered Persons**. We may reasonably require that a Covered Person be examined if a question or dispute about the provision of or payment for Covered Services arises. The exam will be performed by a Participating Provider acceptable to us. We will pay for the exam.

P. **Right of Recovery.** If we pay for Health Care Services that, according to the terms of the Contract, should not have been paid, we reserve the right to recover such amounts from whom they have been paid (including the Covered Person or Provider) or any other appropriate party.

Q. **Contract is not a Medicare supplement policy**. Any Covered Services that are covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled. The benefits under this Contract for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be Primary. Where Medicare is Primary, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

R. **Contract is Not Worker's Compensation Insurance**. The coverage provided under this Contract does not replace, supplement or provide a substitute for benefits to which a

Covered Person is entitled under worker's compensation, occupational disease, and similar laws. The Contract does not cover Health Care Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's compensation, occupational disease and similar laws, even when the circumstances below are present.

(1) If the Covered Person's employer is not properly insured or self-insured under such laws.

(2) When a Covered Person refuses to use his or her employer's designated Provider.

(3) When a Covered Person has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

A Covered Person must contact his employer or its worker's compensation or occupational disease insurer for the provision or payment of such Health Care Services.

S. General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within our control we will pay benefits for Covered Services as provided in this Contract to the extent that facilities and personnel are then available, and we shall have no liability or obligation for delay or failure to provide Covered Services due to lack of available facilities or personnel.

T. Typographical or Administrative Error. Typographical or administrative errors shall not deprive a Covered Person of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

U. Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on the Effective Date shall apply. Any Contract provision which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

V. Governing Law. This Contract will be subject to the laws of the state of Indiana.

W. Severability. In the event that any provision in the Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

[Schedule of Benefits]

[Insert logo left/center/right]

INDIVIDUAL CONTRACT
[Issued through the Indiana Marketplace]
(herein called the "Contract")

[Product Name]

Issued by:

[Indiana University Health Plans, Inc.]
an Indiana domestic health maintenance organization
950 North Meridian Street
Indianapolis, Indiana 46204

[This coverage is issued through the Indiana Marketplace.] This Contract sets forth in detail your rights and obligations as a Subscriber. It is important that you **read this Contract carefully.** This Contract includes limitations and exclusions. You should familiarize yourself with its terms and conditions before receiving Health Care Services. Capitalized terms have the meaning set forth in the Definitions sections.

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, you may return it to us or the agent who sold it to you within 10 days after your receipt. Your premium will be refunded and this Contract with be void from its start. Any Health Care Services received during this 10-day period are solely your responsibility.

Benefits under this Contract may vary depending on other medical expense insurance you may have.

If you have questions related to your health insurance coverage, you may contact us at [toll free number] [or the Indiana Marketplace at www.healthcare.gov or [toll free number].]

[signature]
President

[**DISCLAIMER:** The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace.]

TABLE OF CONTENTS

PAGE

ARTICLE 1. DEFINITIONS 1
ARTICLE 2. ELIGIBILITY AND ENROLLMENT. 9
ARTICLE 3. YOUR FINANCIAL OBLIGATIONS 16
ARTICLE 4. COVERED SERVICES 19
ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS 54
ARTICLE 6. OBTAINING COVERED SERVICES 63
ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES. 65
ARTICLE 8. PAYMENT FOR COVERED SERVICES 72
ARTICLE 9. COORDINATION OF BENEFITS 74
ARTICLE 10. TERMINATION OF COVERAGE 79
ARTICLE 11. GRIEVANCE PROCEDURES 83
ARTICLE 12. GENERAL PROVISIONS 86

ARTICLE 1. DEFINITIONS

[In this Contract, the terms “we”, “us” or “our” refer to [Indiana University Health Plans, Inc.] The term “you” refers to you, the Subscriber, who obtained this coverage through the Indiana Marketplace.]

[In this Contract, the terms “we”, “us” or “our” refer to [Indiana University Health Plans, Inc.]. The term “you” refers to you, the Subscriber, in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.]

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.

Approved Clinical Trial – a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

(a) A trial that is approved or funded by one, or a combination, of the following.

(a) The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services.

(b) The United States Food and Drug Administration.

(c) The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(d) The United States Department of Veteran’s Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).

(e) The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).

(f) The Centers for Disease Control and Prevention.

(g) The Agency for Health Care Research and Quality.

(h) The Centers for Medicare and Medicaid Services (CMS).

(i) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks.

(j) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(k) A qualified non-governmental research entity in guidelines issued by the National Institutes of Health for center support grants.

(2) A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.

(3) A study or investigation done for drug trials which are exempt from the investigational new drug application.

For purposes of this definition, the term "life threatening condition" means any disease or condition from which death is likely unless the disease of condition is treated.

Behavioral Health – a physical or behavioral condition having an emotional or psychological origin or effect, including substance abuse. Behavioral Health Services include mental health services and substance abuse services.

Benefits – your right to payment for Covered Services under this Contract subject to the terms, conditions, limitations, and exclusions of this Contract.

Child or Children – a child of the Subscriber or Subscriber's spouse, including any of the following until the Child attains the age of 26.

- Natural child,
- Stepchild,
- Legally adopted child,
- Child placed for the purpose of adoption, or
- Child placed under legal guardianship or legal custody.

Child includes a child of any age who is incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 26 and the Subscriber principally supports the Child. Proof of the disability must be submitted to us within thirty-one (31) days of the child's 26th birthday. For two years we may require proof of the child's continuing disability and dependency at reasonable intervals. After two years, we may require proof of the child's disability and dependency no more than once per year.

Coinsurance – a percentage of the Allowed Amount that you must pay for certain Covered Services. Coinsurance amounts are set forth in the Schedule of Benefits.

Contract – this individual contract issued by [Indiana University Health Plans, Inc.] which provides Benefits for Covered Services received by the Subscriber and enrolled Dependents. The term Contract includes the Schedule of Benefits, any application, amendments and riders.

Copayment – a fixed amount you pay to a Provider for a Covered Service. The amount of a Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

Cosmetic Services – Health Care Services primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons.

Cost Sharing – the amount you are required to pay for Covered Services. Cost Sharing can be in the form of Copayments, Coinsurance or Deductibles.

Covered Person – you or any Dependent who meets all applicable eligibility requirements for coverage under this Contract, is enrolled as provided in this Contract, and for whom the required premium payment has been received by us.

Covered Services – Health Care Services performed, prescribed, directed or authorized by a Provider and for which this 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 this Contract is in force.
- Not experimental/investigative.
- Authorized in advance by us if Precertification is required under this Contract.
- Not excluded or limited by this Contract.

Deductible – the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The amount of the Deductible is set forth in the Schedule of Benefits.

Dependent – a person who is either the Subscriber's legal spouse or a Child.

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 [website] 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.

Durable Medical Equipment – Medical equipment that:

- can withstand repeated use and is not disposable,
- is used to serve a medical purpose,
- is generally not useful to a person in the absence of a Sickness or injury,
- is appropriate for use in the home, and
- is the most cost-effective type of medical apparatus appropriate for the condition.

Effective Date – the date when coverage under this Contract begins.

Emergency Medical Condition or Emergency – a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent 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 woman, the health of the woman or her unborn child) in serious jeopardy.

- Serious impairment to a person's bodily functions.
- Serious dysfunction of a bodily organ or part of a person.

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, 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, 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 woman 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 woman or the unborn child.

FDA – the United States Food and Drug Administration.

Grace Period – the time period for payment of premium set forth in Article 3 Section B.

Health Care Services – medical or health care services, whether or not covered under this 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.

Indiana Marketplace – the health benefit exchange established by the Affordable Care Act for the state of Indiana.

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

Medically Necessary – those Health Care Services that we determine to be all of the following.

(4) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for your illness, injury or disease.

(5) Required for the direct care and treatment or management of your illness, injury or disease.

(6) If not provided, your condition would be adversely affected.

(7) Provided in accordance with generally accepted standards of medical practice.

(8) Not primarily for the convenience of you, your family, the physician or another prescribing Provider.

(9) 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 your 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 your 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 used in this 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 – 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 this Contract.

Non-Participating Hospital – a Hospital that has not entered into a contractual agreement with us or is not otherwise engaged by us to provide Health Care Services to Covered Persons under this 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 Covered Persons under this Contract.

[**Open Enrollment Period** – the number of days each year during which individuals may enroll in a Qualified Health Plan through the Indiana Marketplace.]

[**Open Enrollment Period** – the number of days each year during which individuals may enroll for coverage under this Contract.]

Out of Pocket Maximum – the maximum amount you will pay for Covered Services in a Plan Year.

Outpatient – receipt of Health Care Services while not an Inpatient.

Participating Hospital – a Hospital 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 Covered Persons under this Contract.

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 Covered Persons under this Contract.

Plan Year – the calendar year during which this Contract is in effect. This Plan Year will be the 12 month calendar year except that if the Subscriber's Effective Date is after January 1st the Plan Year will begin on the Effective Date and end December 31st.

Precertification – 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.

Prescription Drug – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product, insulin, diabetic supplies, and syringes.

Prescription Legend Drug – A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

Primary Care Physician or 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 your medical care under this Contract.

Provider – a doctor, Hospital, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

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.

(1) The Health Care Service that is the subject of the Approved Clinical Trial.

(2) 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.

(3) 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.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) 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.

(6) A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.

(7) A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Qualified Health Plan – a health plan offered on the Indiana Marketplace that satisfies the requirements set forth under the Affordable Care Act (42 U.S.C. 18021(a)(1)).

[**Qualified Individual** – an individual who has been determined by the Indiana Marketplace to be eligible to enroll in a Qualified Health Plan.]

Schedule of Benefits – the part of this Contract that sets forth Cost Sharing, Out of Pocket Maximums, limitations and other information regarding your coverage under this Contract.

Service Area – the counties in which we are authorized to offer a qualified health plan. Our Service Area is [insert list of counties].

Sickness – a physical illness, disorder, or disease. Sickness does not include Behavioral Health conditions.

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.

[**Special Enrollment Periods** – enrollment periods administered by the Indiana Marketplace that occur outside of the Open Enrollment Period. Qualified Individuals and their dependents who are eligible for a Special Enrollment Period may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another during a Special Enrollment Period set for them by the Indiana Marketplace.]

[**Special Enrollment Periods** – enrollment periods administered by us that occur outside of the Open Enrollment Period.]

Spouse – the Subscriber's legal spouse.

Therapeutic Abortion – an abortion performed to save the life or health of the mother, or as a result of incest or rape

Urgent Care Claim – 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 your life, health or ability to reach and maintain maximum function.

- In the opinion of physicians familiar with your condition, would subject you to severe pain that cannot be adequately managed unless we approve the Claim.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT.

[This Contract is available through the Indiana Marketplace. The Benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Indiana Marketplace to be Qualified Individuals.]

A. **You as an Individual:** To be eligible for coverage as a Subscriber, an individual must meet the eligibility requirements listed below at the time of application and throughout the Plan Year.

(1) [Determined by the Indiana Marketplace to be a Qualified Individual for purposes of enrollment in a Qualified Health Plan.] [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective.]

(2) [Not incarcerated.] [Agree to pay the cost of the Premium that we require.]

(3) [A United States citizen or lawfully present non-citizen.] [Submit proof satisfactory to us to confirm Dependent eligibility.]

(4) A resident of the State of Indiana.

(5) Not entitled to or enrolled in Medicare or Medicaid.

(6) Not covered by any other group or individual health benefit plan.

B. **Your Dependents:** To be eligible as a Dependent, another person must either be your Spouse or your Child.

C. [**Other Rules About Eligibility.** No one will be denied enrollment or re-enrollment in this Contract because of health status, or the existence of a pre-existing physical or mental condition.]

D. **Open Enrollment**.

(1) [Notice of Annual Open Enrollment. Each calendar year the Indiana Marketplace will provide you with a written annual open enrollment notification no earlier than September 1, and no later than September 30.]

[Notice of Annual Open Enrollment. Each calendar year we will provide you with a prior written notice of the Open Enrollment Period.]

(2) [2015 Open Enrollment Period. For this Plan Year beginning on January 1, 2015, the Open Enrollment period begins on November 15, 2014 and extends through February 15, 2015.]

(3) [Effective Dates for Coverage Selected During 2015 Open Enrollment. For this Plan Year beginning on January 1, 2015, the following Effective Dates will apply:

(a) January 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace on or before December 15, 2014.

(b) February 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from December 16, 2014 through January 15, 2015.

(c) March 1, 2015, for Qualified Health Plan selections received by the Indiana Marketplace from January 16, 2015 through February 15, 2015.]

(4) [Effective Dates for Coverage Selected During Annual Open Enrollment. The Effective Date for coverage selected during Open Enrollment is the first day of the following month if we receive the application and initial premium payment between the 1st and 15th of the month. If we receive the application and initial premium payment after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (for example: An application and initial premium payment received on January 20th will have an Effective Date of March 1st)]

E. [**Special Enrollment Period.**

(1) Special Enrollment Triggering Events. The Indiana Marketplace must allow Qualified Individuals and their Dependents to enroll in a Qualified Health Plan or change from one Qualified Health Plan to another as a result of experiencing any of the following triggering events:

(a) Loss of Minimum Essential Coverage.

(b) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(c) Gaining status as a citizen, national, or lawfully present individual.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services ("HHS"), or its instrumentalities as evaluated and determined by the Indiana Marketplace. In such cases, the Indiana Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to a new service area of the Indiana Marketplace.

(h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(i) Demonstration to the Indiana Marketplace, in accordance with guidelines issued by HHS, that you or your Dependent meets other exceptional circumstances as the Indiana Marketplace may provide.

(j) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.)

(2) Indiana Marketplace Administration of Special Enrollments. For additional information on special enrollment triggering events and how to enroll in or change a Qualified Health Plan during a Special Enrollment Period, you should contact the Indiana Marketplace at [toll free number] or visit the Indiana Marketplace website at [www.healthcare.gov].

(3) Notice Requirement for Special Enrollments. Unless specifically stated otherwise in the applicable Indiana Marketplace rules, a Qualified Individual or Dependent has sixty (60) days from the date of a special enrollment triggering event to select a Qualified Health Plan.

(4) Special Enrollment Effective Dates. The Effective Date for coverage obtained under this Contract during a Special Enrollment Period depends on the type of triggering event that qualified the individual and/or dependent for the Special Enrollment Period as well as the date the Indiana Marketplace received the Qualified Individual's Qualified Health Plan selection.

(a) For a Qualified Health Plan selection received from the first (1st) through the fifteenth (15th) day of any month, the Effective Date will be the first (1st) day of the following month; and

(b) For a Qualified Health Plan selection received from the sixteenth (16th) through the last day of any month, the Effective Date will be the first (1st) day of the second following month.]

E. [**Changes Affecting Eligibility and Special Enrollment Periods.**

(1) Special Enrollment Triggering Events. A Special Enrollment Period is a period during which an eligible individual who experiences certain triggering events or changes in eligibility may enroll in this Contract, outside of the Open Enrollment period.

(2) Length of Special Enrollment Period. Unless otherwise stated, an eligible individual has 60 days from the date of a triggering event to enroll an eligible individual in this Contract.

(3) Triggering Events

(a) Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, misrepresentation of a material fact or failure to pay premium.

(b) Loss of Minimum Essential Coverage due to dissolution of marriage.

(c) Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption.

(d) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of error, misrepresentation, or inaction of an officer, employee, or agent of the Indiana Marketplace or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Indiana Marketplace.

(e) Violation by a Qualified Health Plan of a material provision of its contract.

(f) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(g) Relocation to new service area of the Indiana Marketplace.

(h) The Indiana Marketplace determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of premium tax credit or cost sharing reductions was the result of misconduct on the part of a non-Indiana Marketplace entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure of the non-Indiana Marketplace entity to comply with all applicable federal or state standards, as determined by the Indiana Marketplace.]

F. Adding New Dependents Under A Special Enrollment Period

(1) Newly Born Children. If you have a new Dependent as a result of birth, coverage for your new Dependent is automatically provided from the moment of birth for up to thirty-one (31) days. Coverage for your new Dependent shall continue beyond the initial thirty-one (31) days, provided you [request a Special Enrollment Period through the Indiana Marketplace to add your new Dependent to this Contract] [submit a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, if any[, within 60 days after the birth of the new Dependent]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days after the date of birth. The Effective Date will be the date of birth.]

(2) Adopted Children. If you have a new Dependent as a result of adoption, coverage for your new Dependent is automatically provided from the earlier of

the date of placement for the purpose of adoption or the date of the entry of an order granting you custody of the child for purposes of adoption, for up to thirty-one (31) days. Coverage for your new Dependent shall continue beyond the initial thirty-one (31) day period provided you [request a Special Enrollment Period through the Indiana Marketplace to add your new Dependent to this Contract] [submit a form to us to add your new Dependent under this Contract] and we receive payment for additional applicable premium, in any[, within 60 days following the date of adoption or placement for adoption]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of adoption or placement of adoption.] The Effective Date will be the earlier of the date of adoption or placement of adoption.

(3) Adding a Child due to Award of Guardianship. If you or your spouse files an application for an appointment of guardianship for a Child, an application to cover the Child under this Contract must be submitted to [the Indiana Marketplace] [us] within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

(4) Qualified Medical Child Support Order. If you are required by a Qualified Child Support Order or court order, as defined by applicable state and federal law, to enroll your Child under this Contract, and the Child is otherwise eligible for the coverage, [the Indiana Marketplace] [we] will permit your Child to enroll in this Contract, and we will provide the benefits of this Contract in accordance with the applicable requirements of such court order.

A Child's coverage under this provision will not extend beyond the Dependent attaining age 26. Any claims payable under this Contract will be paid, at our discretion, to the Child or the Child's custodial parent or legal guardian, for any expenses paid by the Child, custodial parent or legal guardian. We will make information available to the Child, custodial parent or legal guardian on how to obtain benefits and submit claims to us directly.

(5) Spouse or Loss of Minimum Essential Coverage. If you have a new Dependent as a result of marriage, or due to your new Dependent's loss of Minimum Essential Coverage, you may elect to enroll your new Dependent in this Contract, provided you [request a Special Enrollment Period from the Indiana Marketplace to add your new Dependent to this Contract] [submit to us a form to add your new Dependent] and we receive payment for additional applicable premium, if any[, within 60 days from the date of marriage or the loss of Minimum Essential Coverage]. [The Special Enrollment Period request must be submitted to the Indiana Marketplace within sixty (60) days from the date of marriage or the loss of Minimum Essential Coverage.] The Effective Date will be on the first (1st) day of the month following the date of marriage or loss of Minimum Essential coverage.

(a) "Loss of Minimum Essential Coverage" includes loss of eligibility for coverage as a result of any of the following:

(a) Legal separation or divorce.

(b) Cessation of dependent status (such as reaching the maximum age to be eligible as a Dependent under this Contract).

(c) Death of an employee; termination of employment; reduction in the number of hours of employment; or any loss of eligibility for coverage after a period that is measured by any of the foregoing.

(d) Individual who no longer resides, lives or works in the service area.

(e) A situation in which a health benefit plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Termination of employer contributions.

(g) Exhaustion of COBRA continuation of coverage.

(b) "Loss of Minimum Essential Coverage" does not include termination or loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(b) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact

If you do not enroll your new Dependent during the time periods stated above, he or she will not be added to your coverage until the next Open Enrollment Period.

G. Notification of Changes.

(1) Responsibility to Notify [the Indiana Marketplace] [Us]. You are required to notify [the Indiana Marketplace] [us] of any changes in your eligibility or the eligibility of your Dependents for Benefits under this Contract. [The Indiana Marketplace] [We] must be notified of any changes in eligibility as soon as possible, but not later than thirty (30) days from the date of the change in eligibility status. This may include changes in address, marriage, divorce, death, incarceration, change of Dependent disability or dependency status, change in Medicare or Medicaid eligibility status, etc. Notice of a change in eligibility must be provided to [the Indiana Marketplace in a form required and approved by the Indiana Marketplace] [us in writing and on a form approved by us]. Such notifications must include all information required to effectuate all necessary changes.

(2) Failure to Notify [Indiana Marketplace] [Us]. Failure to notify [the Indiana Marketplace] [us] of persons no longer eligible for coverage under this Contract will not obligate us to provide services to those no longer eligible. Our acceptance of payments for persons no longer eligible for services will not obligate us to pay for such services.

(3) Effective Date of Termination Due to Change in Eligibility. Regardless of whether we receive timely notice, a Covered Person's coverage will terminate on the [last day of the month following the date] [day] such Covered Person ceases to be eligible for coverage under this Contract. [We have the right to bill you for the cost of any Health Care Services provided to a Covered Person during the period such Covered Person is not eligible under this Contract.] If you think there are reasons coverage of the person experiencing the change should continue, you must notify [the Indiana Marketplace] [us] of the reasons for the continuation of the coverage no later than thirty-one (31) days after the date coverage for the Dependent would otherwise terminate.

(4) [Statements and Forms. You shall complete and submit to us applications and other forms or statements we may request. You represent to the best of their knowledge and belief that all information contained in such applications, forms, questionnaires, and statements submitted to us is true, correct and complete. You understand that all rights to Benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you or a Covered Person may result in termination or rescission of coverage.]

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A. Premium

(1) You must pay premium to us each month for coverage under this Contract. Your premium rate is determined using the following acceptable rating factors: age, tobacco use, family size and geography.

(a) Tobacco use impacts the determination of your premium. [Upon enrollment through the Indiana Marketplace] [During the enrollment application process], you will attest to tobacco use by you and/or your Dependents. If you report false or incorrect information about tobacco use, we may retroactively apply the appropriate tobacco rating factor to your premium as if the correct information had been accurately reported from the Effective Date.

(b) Your age impacts the determination of your premium rate. If your age has been misstated, we will adjust the premiums to the amount premiums would have been if purchased at the correct age.

(2) You will receive a monthly bill for your premium. Your payment is due by the date stated in your bill subject to the any applicable Grace Period stated in this Contract. You must pay your premium when it is due for coverage to continue.

(3) We reserve the right to change the premium on an annual basis. We will provide you with thirty (30) days prior written notice of any change in the premium.

(4) Your premium may change if Dependents are enrolled or disenrolled in your coverage. If a premium increase is necessary, we will bill you for the additional amount due. If this amount is not paid, this Contract will be cancelled at the end of the applicable Grace Period and you will receive a refund of any unearned premium. If a decrease in premium is appropriate we will notify you of the decrease and refund any excess premium to you.

(5) If premium has been paid for any period of time after the date you cancel this Contract, we will refund that premium to you. The refund will be for the period of time after your coverage ends. If a Covered Person dies while this Contract is in force, we will refund any premium paid for such Covered Person for any period after the date of the Covered Person's death to you or your estate.

B. Grace Period

(1) [General Grace Period.] Following payment of the initial premium, a Grace Period of thirty (30) days shall be granted for the payment of any premium. This Grace Period shall not extend beyond the date this Contract terminates. During the Grace Period this Contract shall continue in force. Any claims incurred and submitted during the Grace Period will not be considered for payment until premium is received. If premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of coverage.

(2) [Grace Period for Persons Receiving Advance Payments of the Premium Tax Credit. If you are receiving advance payments of the premium tax credit and at least one full month's premium has been paid during this Plan Year, a Grace Period of three (3) consecutive months shall be granted for the payment of any premium. During this 3-month Grace Period, we shall do all of the following listed below.

(a) Pay for Covered Services during the first (1st) month of the Grace Period and may pend claims for Covered Services rendered to you in the second and third months of the Grace Period.

(b) Notify the Department of Health and Human Services of such non-payment

(c) Notify Providers of the possibility for denied claims during the second and third months of the Grace Period.]

C. Deductible.

(1) The Deductible is the amount you must pay for Covered Services in a Plan Year before we will pay Benefits for Covered Services. The Deductible may not apply to all Covered Services. The Deductible is set forth in the Schedule of Benefits.

(2) Copayments do not count towards the Deductible.

D. Coinsurance

(1) Coinsurance is a percentage of the Allowed Amount that you must pay for Covered Services. You are responsible for payment of Coinsurance after you have met the Deductible and until you reach the Out of Pocket Maximum. Coinsurance is set forth in the Schedule of Benefits.

(2) Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

E. Copayments

(1) Copayments are a fixed amount you pay to a Provider for a Covered Service. Copayments are typically paid when you receive the Covered Service. The amount of the Copayment may vary by the type of Covered Service. Copayments are set forth in the Schedule of Benefits.

(2) Copayments do not apply to the Deductible. Copayments apply towards the Out of Pocket Maximum.

F. Out of Pocket Maximum

(1) The Out of Pocket Maximum is the maximum amount you will pay for Covered Services in a Plan Year. The Out of Pocket Maximum is listed on the Schedule of Benefits.

(2) Once the Out of Pocket Maximum is reached, we will pay 100% of the Benefits for Covered Services.

(3) Copayments, Coinsurance and the Deductible apply towards the Out of Pocket Maximum.

G. Payments for Non-Covered Services. You are responsible for payment of all expenses for Non-Covered Services.

ARTICLE 4. COVERED SERVICES

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides Benefits for the following Covered Services. Payment for Covered Services is limited by any applicable Coinsurance, Copayment, or Deductible set forth in this Contract including the Schedule of Benefits. To receive maximum Benefits for Covered Services, you must follow the terms of this Contract, including receipt of care from a Primary Care Physician and Participating Providers as well as obtaining any required Precertification.

You are responsible for all expenses incurred for Non-Covered Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

A. Ambulance Services

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

(a) From your home, scene of accident or medical Emergency to a Hospital,

(b) Between Hospitals,

(c) Between a Hospital and Skilled Nursing Facility, or

(d) From a Hospital or Skilled Nursing Facility to your home.

(2) Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

(3) Other vehicles which do not meet the definition of Ambulance Services are not Covered Services. Ambulette services are Covered Services when appropriate.

(4) Ambulance Services are a Covered Service only when Medically Necessary, except:

(a) When ordered by an employer, school, fire or public safety official and the Covered Person is not in a position to refuse, or

(b) When a Covered Person is required by us to move from a Non-Participating Provider to a Participating Provider.

(5) Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health.

(6) Non-Covered Services for Ambulance include but are not limited to:

(a) A trip to a physician's office or clinic,

(b) A trip to a morgue or funeral home, or

(c) Any ambulance usage for the convenience of a Covered Person, family or Provider.

B. Behavioral Health Care Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Covered Services include:

(a) Inpatient services. Individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

(b) Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

(c) Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health conditions. Intensive Outpatient programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient programs may offer group, DBT, individual, and family services.

(d) Outpatient Treatment, or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

(2) Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

(3) To assist you in obtaining appropriate and quality care, we will ask for a treatment plan after you have been evaluated after 10 Outpatient visits. We may discuss the goals of treatment and changes in the treatment plan, including

alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

(4) Non-Covered Services include the following.

(a) Custodial or domiciliary care.

(b) Supervised living or halfway houses.

(c) Services or care provided or billed by a residential treatment center, school, halfway house.

(d) Custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(e) Services related to non-compliance of care if the Covered Person ends treatment for substance abuse against the medical advice of the Provider.

C. Routine Care Costs as Part of a Cancer or Other Life Threatening Disease or Condition Clinical Trial

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits are available for Routine Care Costs rendered as part of an Approved Clinical Trial if the services are otherwise Covered Services under this Contract.

(2) Your Primary Care Physician must give us notice of your participation in an Approved Clinical Trial.

(2) Non-Covered Services include the following.

(a) A Health Care Service that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient.

(b) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service or investigational drug that is the subject of the clinical trial.

(c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.

(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the clinical trial.

(e) An item or drug provided by the clinical trial sponsors free of charge for any patient.

(f) A service, item, or drug that is eligible for reimbursement by a person or entity other than us, including the sponsor of the clinical trial.

D. Dental Services Related to an Injury

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient services, Physician Home Visits and Office Services, Emergency Services and Urgent Care Center Services for dental work and oral surgery are Covered Services if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Covered Person's condition.

(2) Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

(3) For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

(4) Covered Services include, but are not limited to the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations
- Prosthetic services
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia

(5) Anesthesia and Hospital charges for dental care for a Covered Person less than 19 years of age or a Covered Person who is physically or mentally disabled, are covered if the Covered Person requires dental treatment to be given in a Hospital or Outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Covered Person's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

E. Diabetic Equipment, Education and Supplies

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when ordered in writing by a physician or a podiatrist and provided by a physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

(2) Covered Services include physician prescribed equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances”, “Preventive Care Services”, and “Physician Home Visits and Office Services”.

F. Diagnostic Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services include the following.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).

- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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

(3) For Diagnostic services other than those approved to be received in a physician's office, you may be required to use a laboratory that is a Participating Provider.

(4) When Diagnostic radiology is performed in a Participating Provider's Office, no Copayment is required, however, any Coinsurance will still apply.

G. Emergency Care Services and Urgent Care Center Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit limitation. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Benefits for treatment of an Emergency Medical Condition and Emergency screening and stabilization services without Precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions.

(2) Benefits for Emergency Care include facility costs and physician services, supplies and Prescription Drugs charged by that facility.

(3) Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Copayment or Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify us or verify that your physician has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary. If your Provider is a Non-Participating Provider, you will be financially responsible for any care we determine is not Medically Necessary.

(4) Often an urgent rather than an Emergency Medical Condition exists. An urgent medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Such medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Primary Care Physician prior to receiving care for an urgent medical problem and your Primary Care Physician

authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Care Services.

H. Home Care Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Covered Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Care Services.
- Nutritional Guidance.
- Home Health Aide Services. The Covered Person must be receiving skilled nursing or therapy. Health Care Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Care Services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services in the home (except for Massage, Music, and Manipulation Therapy). Home Care visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

(3) Non Covered Services include the following.

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

(4) Home infusion therapy will be paid only if you obtain Precertification. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

I. Hospice Services

For all Covered Services, see the schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit limitations. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) 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 (6) months or less, as certified by the attending physician and hospice medical director. Covered Services will continue if the Covered Person lives longer than six (6) months, provided the hospice medical director or other hospice physician recertifies that the Covered Person is terminally ill.

(2) Covered Hospice Services include the following.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Care Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

(3) Non-Covered Services include services provided by volunteers and housekeeping services.

J. Inpatient Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Inpatient services include the following.

(a) Charges from a Hospital, Skilled Nursing Facility or other Provider for room, board and general nursing services.

(b) Ancillary services.

(c) Professional services from a physician while an Inpatient.

(2) Room, Board, and General Nursing Services include either of the following.

(a) A room with two or more beds or a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

(b) A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

(3) Ancillary (Related) Services include any of the following.

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

(4) Professional Services include the following.

- Medical care visits limited to one visit per day by any one physician.
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, and EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

(5) When a Covered Person is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

K. Maternity Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, Therapeutic Abortion, and ordinary routine nursery care for a healthy newborn.

(2) If the Covered Person is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider for the Health Care Services to be Covered Services. If the Covered Person is pregnant on her Effective Date and is in her second or third trimester of pregnancy, she may receive Benefits for Health Care Services from a Non-Participating Provider if she requests and receives written approval from us.

(3) If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance or Copayment.

(4) If Maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

(5) Coverage for the Inpatient postpartum stay for a Covered Person and her newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if both or the following are met.

(a) In the opinion of your attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the following.

- The antepartum, intrapartum, and postpartum course of the mother and infant.
- The gestational stage, birth weight, and clinical condition of the infant.
- The demonstrated ability of the mother to care for the infant after discharge.
- The availability of post discharge follow-up to verify the condition of the infant after discharge.

(b) The mother of the newborn child agrees with the recommendation for a shorter length of stay.

(6) Covered Services include at-home post-delivery care visits at your residence by a physician or nurse performed no later than 48 hours following discharge from the Hospital. Coverage for this visit includes, but is not limited to parent education, assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At your discretion, this visit may occur at the physician's office.

(7) Covered Services include the following tests and examinations given at the earliest feasible time to the newborn child for the detection of the following disorders.

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

L. Medical Supplies, Durable Medical Equipment and Appliances

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Medical and Surgical Supplies. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a physician's office, including but not limited to, Depo-Provera and Remicade. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

(a) Covered Services include the following.

- Allergy serum extracts.
- Chem strips, Glucometer, Lancets.

- Clinitest.
- Needles/syringes.
- Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not Covered Services.

(b) Non-Covered Services include the following.

- Adhesive tape, band aids, cotton tipped applicators.
- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Vitamins.
- Medijectors.

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

(3) Durable Medical Equipment - The rental (or, at our option, the purchase) of Durable Medical Equipment prescribed by a Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples of Durable Medical Equipment include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price.

(a) We will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Covered Person, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is a Covered Service.

(b) Covered Services include the following.

- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pump for IV fluids and medicine.
- Glucometer.

- Tracheotomy tube.
- Cardiac, neonatal and sleep apnea monitors.
- Augmentive communication devices are Covered Services when we approve based on the Covered Person's condition.
- CPAP machines when indicated for sleep apnea.

(c) Non-Covered Services include the following.

- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats.
- Rental of equipment if the Covered Person is in a Facility that is expected to provide such equipment.
- Translift chairs.
- Treadmill exerciser.
- Tub chair used in shower.

(4) Prosthetics. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

(a) Prosthetic devices should be purchased not rented. Applicable taxes, shipping and handling are Covered Services.

(b) Covered Services include the following.

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Plan Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction

is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered Services when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered Services. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be a Covered Service.

- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Plan Year).

(c) Non-Covered Services include the following.

- Dentures, replacing teeth or structures directly supporting teeth.
- 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.

(5) Orthotic Devices. The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered Services. The casting is a Covered Service when an orthotic appliance is billed with it, but not if billed separately.

(a) Covered Services include the following.

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

(b) Orthotic appliances may be replaced one time per Plan Year unless specifically approved in writing by us. Additional replacements will be allowed for Covered Persons under age 18 due to rapid growth, or for any Covered Person when an appliance is damaged and cannot be repaired.

(c) Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

(d) Non-Covered Services include the following.

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

(6) Prosthetic limbs & Orthotic custom fabricated brace or support. Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be a Covered Service if they are determined by your physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities, and are not solely for comfort or convenience.

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

(b) Prosthetic limbs and orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

(7) Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below, as approved by us.

(a) The repair, adjustment or replacement of the purchased equipment, supply or appliance is a Covered Service if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.

- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

(b) Replacement of purchased equipment, supplies or appliance may be a Covered Service if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

(c) Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

M. Outpatient Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital or other facility as determined by us. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation.

(2) Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to Article 3 Section B for Behavioral Health Services covered by this Contract.

(3) Professional charges only include services billed by a physician or other professional.

(4) When Diagnostic Services or other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Service, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

(5) For Emergency Care refer to the section titled Emergency Services.

N. Autism Spectrum Disorder Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Autism Spectrum Disorder means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(2) Coverage is provided for the treatment of Autism Spectrum Disorders, including behavioral therapies such as Applied Behavior Analysis (ABA). Benefits are limited to Health Care Services prescribed by your physician in accordance with a treatment plan. Coverage for Health Care Services will be provided as prescribed by your treating physician in accordance with the treatment plan.

(3) Any exclusion or limitation in this Contract in conflict with the coverage described in this section will not apply.

(4) Coverage for Autism Spectrum Disorders will not be subject to limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Contract.

O. Physician Home Visits and Office Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service a Health Care Service must be Medically Necessary.

(1) Covered Services include care provided by a physician, including employees of the physician such as an advanced practice nurse or physician assistant, in his/her office or your home. Refer to the sections titled Preventive Care, Maternity Care, Home Care Services, and Behavioral Health Care Services for services covered by this Contract. For Emergency Care refer to the Emergency Services section.

(2) Office visits for medical care and consultations to examine, diagnose, and treat a Sickness or injury performed in the physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a physician's office, no Copayment is required however Coinsurance will apply.

(3) Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

(4) Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

(5) Surgery and surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

(6) Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a physician or other professional Provider.

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

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

(2) Preventive Care Services in this section shall meet requirements as determined by federal and state law.

(a) Health Care Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF. Covered Services include the screenings for following.

- Breast cancer.
- Cervical cancer.
- Colorectal cancer.
- High Blood Pressure.
- Type 2 Diabetes Mellitus.
- Cholesterol.
- Child and Adult Obesity.
- For Covered Persons age 15 – 65 and other ages at increased risk, Human Immunodeficiency Virus (HIV)
- Depression for adults
- Screening for alcohol misuse

(b) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(c) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Well Baby visits and care.
- Newborn screening for hearing
- Lead screening for children at risk for exposure
- Depression screening for adolescents

(d) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. Covered Services include the following.

- Women's contraceptives, sterilization procedures, and counseling. This includes generic drugs only, unless there is no generic equivalent, obtained from a Participating Pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms and intrauterine devices (IUDs) are also covered. When generic equivalents are available, prescription brand name contraceptives will not be covered under the Preventive Care benefit. Instead, prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the Prescription Drug Benefits section.
- Breastfeeding support, supplies, and counseling.
- Gestational diabetes screening.

(3) Covered Services also include the following services required by state law:

(a) Breast Cancer Screening. The following are Covered Services.

(a) If the female Covered Person is at least 35 years of age, one (1) baseline breast cancer screening mammography performed before she becomes 40 years of age.

(b) If the female Covered Person is less than 40 years of age and is high risk, one (1) breast cancer screening mammography performed every year. A woman is considered "high risk" if she meets at least one (1) of the following.

(A) Has a personal history of breast cancer.

(B) Has a personal history of breast disease proven benign by biopsy.

(C) Has a mother, sister, or daughter who has had breast cancer.

(D) Is at least 30 years of age and has not given birth.

(c) Any additional mammography views that are required for proper evaluation.

(d) Ultrasound services, if determined Medically Necessary by the physician treating the Covered Person.

(b) Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Service for a Covered Person under the age of fifty (50) if the Covered Person is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsymptomatic Covered Person, in accordance with the current American Cancer Society guidelines.

(c) Diagnostic Prostate Cancer Screening. If male Covered Person is at least 50 years of age, one (1) prostate specific antigen test annually is a Covered Service. If a male Covered Person is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test annually is a Covered Service.

Q. Surgical Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes the following.

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

(2) The surgical fee includes normal post-operative care.

(3) We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact us for more information.

(4) Covered Surgical Services include the following.

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

R. Reconstructive Services

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

(2) Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract.

(3) Covered Services are limited to the following.

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

(4) A Covered Person who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive coverage for the following.

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same Deductible, Coinsurance, and Copayment provisions otherwise applicable under this Contract.

S. Sterilization.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

Sterilization is a Covered Service.

T. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Coverage for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

(2) Covered Services include removable appliances for repositioning and related surgery, medical care, and diagnostic services.

(3) Non-Covered Services include the following:

- Fixed or removable appliances that involve movement or repositioning of the teeth.
- Repair of teeth (fillings).
- Prosthetics (crowns, bridges, dentures).

U. Therapy Services.

Benefits are provided for therapy services that can be Rehabilitative or Habilitative. For purposes of this section and the Schedule of Benefits, the following definitions apply:

- Rehabilitation refers to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech therapy and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

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

(2) Physical therapy.

(a) Physical therapy includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve

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

(b) Non-Covered Services include the following.

- Maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness.
- Repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients).
- Range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities.
- General exercise programs, diathermy, ultrasound and heat treatments for pulmonary conditions.
- Diapulse.
- Work hardening.

(3) Speech Therapy. Speech therapy for the correction of a speech impairment.

(4) Occupational Therapy. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

(a) Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

(b) Non-Covered Services include the following.

- Supplies (looms, ceramic tiles, leather, utensils).
- Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again.
- General exercises to promote overall fitness and flexibility.
- Therapy to improve motivation.
- Suction therapy for newborns (feeding machines).
- Soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial.
- Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

(5) Manipulation Therapy. Manipulation Therapy includes osteopathic/chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy

includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

(a) Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any limitation for Manipulation Therapy services as specified in the Schedule of Benefits.

(b) Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

(6) Other Therapy Services

(a) Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

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

(c) Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage this Contract will not require you to receive dialysis treatment at a Participating Provider that is a dialysis facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Participating Dialysis Facility is more than 30 miles from your home, you may, upon our prior written consent, receive treatment at a Non-Participating Provider that is a dialysis facility nearest to your home as Covered Service.

(d) Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

(e) Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to:

- Introduction of dry or moist gases into the lungs.
- Nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication.
- Continuous positive airway pressure ventilation (CPAP).
- Continuous negative pressure ventilation (CNP).
- Chest percussion.
- Therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers.

- Broncho-pulmonary drainage.
- Breathing exercises.

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

V. Physical Medicine and Rehabilitation Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

(2) The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting. Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

(3) Non-Covered Services include the following.

- Admission to a Hospital mainly for physical therapy.
- Long term rehabilitation in an Inpatient setting.

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

W. Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Cost Sharing.

(2) "Covered Transplant Procedure" includes any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

(3) "Transplant Benefit Period" starts one day prior to a covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Procedure and continues to the date of discharge at a Non-Participating Provider Facility.

(4) Transplant services require Precertification.

(5) Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are a Covered Service as routine Diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

(6) Transportation and Lodging. This Contract will provide assistance with reasonable and necessary travel expenses as determined by us when you obtain Precertification and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Covered Person receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must

submit itemized receipts for transportation and lodging expenses in a form satisfactory to us when claims are filed.

(7) Non-Covered Services for transportation and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

X. Prescription Drug Benefits

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) Pharmacy Benefits Manager (PBM).

(a) The Prescription Drug benefits are managed by our Pharmacy Benefits Manager or PBM. The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a mail service pharmacy, a Specialty Pharmacy, and provides clinical management services. The management and other services the PBM provides include, making recommendations to, and updating, the “covered Prescription Drug list” (the “covered Prescription Drug list” is referred to as the “Formulary”), managing a network of retail pharmacies, operating a mail service pharmacy, and operating a Specialty Pharmacy network.

(b) The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of Prescription Drug benefits, such as review for possible excessive use, recognized and recommended dosage

regimens, drug interactions or drug/pregnancy concerns. You may request a copy of the Formulary by calling the Customer Service telephone number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage.

(c) For certain Prescription Drugs, the prescribing Provider may be asked to provide additional information before the PBM and/or we can determine Medical Necessity. We may, in our sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer.

(d) Precertification may be required for certain Prescription Drugs (or the prescribed quantity of a particular Prescription Drug). At the time you fill a prescription, the Participating Pharmacy is informed of the Precertification requirement through the Participating Pharmacy's computer system. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee which is reviewed and adopted by us.

(e) For a list of the current Prescription Drugs requiring Precertification, please contact the Customer Service telephone number on the back of your Identification Card or go to our website at [insert url to formulary]. The Formulary is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the Formulary is not a guarantee of coverage. Your Provider or Participating Pharmacy may check with us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under this Contract.

(2) Therapeutic Substitution of Prescription Drugs. This is a voluntary program designed to inform Covered Persons and Providers about possible substitutes to certain Prescription Drugs. We, or the PBM, may contact you and your prescribing Provider to make you aware of substitution options. Therapeutic substitutes may also be initiated at the time the Prescription Drug is dispensed.

(a) Only you and your Provider can determine whether the therapeutic substitute is appropriate for you.

(b) For questions or issues involving therapeutic substitutes, call the Customer Service telephone number on the back of your Identification Card.

(c) The therapeutic substitutes list is subject to periodic review and amendment.

(3) Step Therapy. Step therapy protocol means that a Covered Person may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Covered Persons access high quality yet cost effective Prescription Drugs. If a Provider decides that the monitored medication is needed the Precertification process is applied.

(4) Participating Specialty Pharmacy. The PBM's Specialty Pharmacy is available to Covered Persons who use Specialty Drugs.

(a) "Specialty Drugs" are Prescription Legend Drugs that are one of the following:

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

(b) Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, subject to a day supply limit for retail and mail service, and the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

(c) Questions regarding Specialty Drugs can be directed to the Customer Service telephone number on the back of your Identification Card.

(d) You may obtain a list of the Participating Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your Identification Card, or review the lists on our website at [insert address].

(5) Covered Services include the following.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Self-administered contraceptives, including oral contraceptives, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the Preventive Care section, please see that section for more details.
- Selected drugs to eliminate or reduce dependence on, or addiction to tobacco and tobacco products.
- Injectables.
- Selected preventive medications are covered with no Copayment or Coinsurance if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations. These medications include the following: vitamin D supplementation, folic acid supplementation, aspirin and oral fluoride supplementation.

(6) In addition to the Exclusions set forth in Article 4, Non-Covered Services include the following.

- Prescription Drugs dispensed by any mail service program other than the PBM's mail service pharmacy, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription.
- Drugs not approved by the FDA except as otherwise prohibited by law.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a physician. This does not apply to drugs used in conjunction with a Diagnostic Service, with chemotherapy performed in the office or drugs eligible for coverage under the Medical Supplies benefit.
- Any drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by this Contract, or which exceed any age limits established by us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility drugs.
- Human growth hormone for children born small for gestational age.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact us for additional information on these Prescription Legend Drugs.
- Refills of lost or stolen medications.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, unless otherwise required by law or approved by us. "Clinically equivalent" means drugs that, for the majority of persons, can be expected to produce similar therapeutic outcomes for a disease or condition.

(7) If you have questions regarding whether a particular Prescription Drug is covered and which Tier a Prescription Drugs fall into, please call the Customer Service telephone number on the back of your Identification Card, or visit our website at [website address].

(8) Each Prescription Drug may be subject to a Deductible, Coinsurance or Copayment. If the prescription includes more than one covered Prescription Drug, a separate Coinsurance or Copayment will apply to each covered

Prescription Drug. Your Copayment will be the lesser of your scheduled Copayment or the Allowable Amount.

(9) The number of days' supply of a Prescription Drug which you may receive is limited. The days' supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days' supply allowed for under this Contract, you should ask your Pharmacist to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

(10) Your Copayment or Coinsurance amount may vary based on whether the Prescription Drug has been classified by us as a first, second, third, fourth or fifth "Tier" Prescription Drug. The determination of Tiers is made by us based upon clinical information, and where appropriate the cost of the Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

(a) Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This Tier will contain low cost and preferred generic medications as well as selected preventive medications that are covered with no Coinsurance or Copayment if the Covered Person meets criteria set forth by the U.S. Preventive Services Task Force A and B recommendations.

(b) Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This Tier will contain non-preferred generic medications.

(c) Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This Tier will contain preferred brand name medications.

(d) Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This Tier will contain non-preferred brand name medications.

(e) Tier 5 Prescription Drugs will have a higher/comparative Coinsurance or Copayment than those in Tier 4. This Tier will contain medications that are considered Specialty Drugs.

We have established a Pharmacy and Therapeutics Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Precertification criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives. The Pharmacy and Therapeutics Committee also determines, where appropriate, the cost of a

Prescription Drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one drug over another in our patient program, and, where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

(11) From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, generic, mail service, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Prescription Drugs or preferred products for a limited period of time.

(12) The amount of Benefits paid is based upon whether you receive the Covered Services from a Participating Pharmacy, including a Participating Specialty Pharmacy, a Non-Participating Pharmacy, or the PBM's mail service program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug.

(13) How you obtain your Benefits depends upon whether you go to a Participating or a Non-Participating Pharmacy.

(a) Participating Pharmacy – Present your written prescription from your physician and your Identification Card to the pharmacist at a Participating Pharmacy. The Participating Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment or Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge and you believe the Prescription Drug should be covered, ask your pharmacist for an itemized receipt and submit it to us for reimbursement consideration.

(b) Specialty Drugs - You or your Provider can order your Specialty Drugs directly from a Participating Specialty Pharmacy, simply call the Customer Service telephone number on the back of your Identification Card. Your Specialty Drug may need Precertification prior to dispensing. Upon approval, your Specialty Drug will be delivered to your physician's office/your specified delivery location based on the physician's order. A clinician will be available to answer any questions you may have in regard to the Specialty Drug and the instructions.

(c) Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy, including a Non-Participating Specialty Pharmacy. You must submit a claim for reimbursement consideration as set forth in Article 8 Section C.

(d) The Mail Service Program – Complete the order and patient profile form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have your physician fax the prescription to the mail service pharmacy. Your physician may also phone in the prescription to the mail service pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the mail service pharmacy when you request a prescription.

(14) Drug Exception Program. This is a program designed to allow Covered Persons to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. The Drug Exception Program is separate from and in addition to the benefit review and appeals processes outlined in Article 7. Please call the Customer Service number on the back of your Identification Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary.

Y. Pediatric Vision Services. The following Health Care Services are Covered Services only for Covered Person through the age of nineteen (19). The Contract only provides Benefits for vision care that is listed in this section.

For all Covered Services, see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. To be considered a Covered Service, a Health Care Service must be Medically Necessary.

(1) A complete pediatric eye exam. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together. The exam may include the following.

- Case History.
- Cover test.
- Ocular Motility.
- Neurological Integrity.
- External Exam.
- Internal Exam.
- Retinoscopy.
- Phorometry testing.
- Point refraction.
- Tonometry.
- Opthalmoscopic exam.
- Confrontation Visual Fields.
- Biomicroscopy.
- Color Vision Testing.
- Diagnosis/Prognosis.
- Recommendations.

(2) Eyeglass Lenses. Lens options include a choice of plastic or polycarbonate. Lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include up to 55 mm in single vision, bifocal, trifocal or lenticular.

(3) Frames. This Contract offers a selection of frames that are covered.

(4) Contact Lenses. Coverage includes the following.

(a) Contact Lens professional fitting fees.

(b) Elective Contact Lenses (elective contact lenses are contacts that are chosen for comfort or appearance).

(c) Non-Elective Contact Lenses are only provided for the following medical conditions.

- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when the patient's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

(d) Medically Necessary contact lenses are available in lieu of ophthalmic lenses and may be subject to Copayments, Coinsurance and limitations. The Provider determines a patient's qualifying criteria at examination and evaluation, and will obtain any necessary Precertification from us for these services.

(5) Low Vision Benefits

(a) Comprehensive Low Vision Exam.

(b) Optical/Non-optical aids.

(c) Supplemental testing.

(6) Non-Covered Services include services incurred for, or in connection with, any of the items below.

- Non-elective contact lenses for any Covered Person who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- For safety glasses and accompanying frames.
- For Inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Covered Person has reached the normal interval for service when seeking replacements.

- For services or supplies not specifically listed in this Contract.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Vision services for Covered Persons over the age of nineteen (19) unless specifically stated in this Contract.

ARTICLE 5. NON-COVERED SERVICES AND EXCLUSIONS

A. **Non-Covered Services**. This Article 5 sets forth services that are excluded from coverage under this Contract and therefore are Non-Covered Services. Non-Covered Services are not covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

B. **Exclusions**. The following are Non-Covered Services:

(1) Services that we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.

(2) Services received from an individual or entity that is not a Provider.

(3) Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.

(4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

(5) Services provided as benefits by any governmental unit, unless otherwise required by law or regulation.

(6) Services for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

(7) Services for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

(8) Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

(9) Court ordered testing or care unless Medically Necessary.

(10) Services for which you have no legal obligation to pay in the absence of this or like coverage.

(11) Charges for consulting with Covered Persons by telephone, facsimile, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Covered Person except as otherwise described in this Contract.

(12) Surcharges for furnishing and/or receiving medical records and reports.

(13) Charges for doing research with Providers not directly responsible for your care.

(14) Charges that are not documented in Provider records.

(15) Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.

(16) Administrative, or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

(18) Services prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

(19) Completion of claim forms or charges for medical records or reports unless otherwise required by law.

(20) Missed or canceled appointments.

(21) Mileage, lodging and meals costs, and other travel related expenses, except as authorized by us or specifically stated as a Covered Service in this Contract.

(22) Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.

(23) Services incurred prior to the Effective Date.

(24) Services incurred after the termination date of this coverage except as specified elsewhere in this Contract.

(25) For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Complications directly related to Cosmetic Services treatment or surgery, as determined by us, are not covered. This exclusion applies even if the original Cosmetic Services treatment or surgery was performed while the Covered Person was covered by another carrier/self-funded plan prior to coverage under this Contract. “Directly related” means that the treatment or surgery occurred as a direct result of the Cosmetic Services treatment or surgery and would not have taken place in the absence of the

Cosmetic Services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.

(26) Maintenance Therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance Therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

(27) Custodial Care, convalescent care or rest cures.

(28) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Covered Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

(29) Services provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

(30) Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

(31) Services or care provided or billed by a school, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

(32) Wilderness camps.

(33) For routine foot care (including the cutting or removal of corns and calluses), Nail trimming, cutting or debriding, Hygienic and preventive maintenance foot care, including but not limited to 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.

(34) Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

(35) Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to the following.

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

(36) 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.

(37) Dental implants.

(38) Dental braces.

(39) Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following.

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer or cleft palate.

(40) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

(41) Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

(42) Bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by us, are not covered. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(43) Marital counseling.

(44) Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

(45) Vision orthotic training.

(46) Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.

(47) Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

(48) Services to reverse voluntarily induced sterility.

(49) Diagnostic testing or treatment related to infertility.

(50) Personal hygiene, environmental control, or convenience items including but not limited to the following.

- Air conditioners, humidifiers, air purifiers.
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals.
- Charges for non-medical self-care except as otherwise stated.
- Purchase or rental of supplies for common household use, such as water purifiers.
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds.
- Infant helmets to treat positional plagiocephaly.
- Safety helmets for Covered Persons with neuromuscular diseases.
- Sports helmets.

(51) Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

(52) Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by us, or as otherwise described in this Contract.

(53) Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.

(54) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

(55) For self-help training and other forms of non-medical self-care, except as otherwise provided in this Contract.

(56) Examinations relating to research screenings.

(57) Stand-by charges of a Provider.

(58) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

(59) Services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

(60) Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Contract.

(61) Manipulation Therapy services rendered in the home as part of Home Care Services.

(62) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. This Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

(63) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

(64) Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

(65) Any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

(66) Surgical treatment of gynecomastia.

(67) Treatment of hyperhidrosis (excessive sweating).

(68) Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by us through Precertification.

(69) Complications directly related to a service or treatment that is a Non-Covered Service under this Contract because it was determined by us to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

(70) Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.

(71) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

(72) Treatment of telangiectatic dermal veins (spider veins) by any method.

(73) Reconstructive services except as specifically stated in this Contract or as required by law.

(74) Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

(75) For non-preventive medical nutritional therapy.

(76) Abortions that are not Therapeutic Abortions.

C. Experimental/Investigative Health Care Services Exclusion. We do not provide coverage for any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be Experimental/ Investigative.

(1) 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.

(a) 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 granted.

(b) Has been determined by the FDA to be contraindicated for the specific use.

(c) Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

(e) 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.

(2) Any Health Care Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by us. In determining whether a Health Care Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

(a) The scientific evidence is conclusory concerning the effect of the Health Care Service on health outcomes.

(b) The evidence demonstrates the Health Care Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects.

(c) The evidence demonstrates the Health Care Service has been shown to be as beneficial for the total population for whom the Health Care Service might be proposed as any established alternatives.

(d) The evidence demonstrates the Health Care Service has been shown to improve the net health outcomes of the total population for whom the Health Care Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(3) Off-Label Drug Treatment. Coverage for a drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

(a) The drug is recognized for treatment of the indication in at least one standard reference compendium.

(b) The drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have

been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the drug's use to be contraindicated or the drug has not been approved by the FDA for any indication.

(4) The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

(a) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof.

(b) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies.

(c) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(d) Documents of an IRB or other similar body performing substantially the same function.

(e) Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.

(f) Medical records.

(g) The opinions of consulting Providers and other experts in the field.

ARTICLE 6. OBTAINING COVERED SERVICES

A. Participating Providers.

(1) Unless otherwise specifically provided in this Contract, in order to receive Benefits under this Contract, a Covered Person must receive Covered Services from a Participating Provider.

(2) The Covered Person is responsible for verifying that a Provider is a Participating Provider. A list of Participating Providers is available online at [insert website] or by calling us at [toll free number].

B. Non-Participating Providers. Health Care Services received from Non-Participating Providers are Non-Covered Services except for the following circumstances.

(1) Emergency Health Care Services.

(a) If we determine that the Health Care Services were not an Emergency, the Health Care Services are Non-Covered Services and you will be responsible for costs associated with the Health Care Services.

(b) Subsequent follow up care by a Non-Participating Provider after the condition is no longer an Emergency is a Non-Covered Service unless specifically authorized by us.

(c) If a Covered Person is hospitalized in a Non-Participating Hospital due to an Emergency, you or the Provider must notify us within 48 hours of the admission. A continued stay after the condition is stabilized and is no longer an Emergency requires our written authorization. We may elect to transfer the Covered Person to a Participating Hospital once it is medically appropriate to do so.

(2) Non-emergency Medically Necessary Health Care Services that cannot be provided by a Participating Provider and for which the Covered Person has obtained a Referral from his/her Primary Care Physician.

(3) Maternity services for a Covered Person who was in her second or third trimester of pregnancy as of her Effective Date as provided in Article 3 Section K.

(4) When our agreement with a Participating Provider terminates, upon your written request, you may continue to receive Covered Services from the Provider for the following time periods.

(a) Up to sixty (60) days.

(b) In the case of Covered Person who is pregnant and in the third trimester of pregnancy, you may continue to receive Covered Services through the term of the pregnancy.

(c) For a Covered Person who is hospitalized until the Covered Person is discharged from Inpatient status.

C. Primary Care Physician.

(1) You must designate a Primary Care Physician for each Covered Person. If you do not select a Primary Care Physician we will assign one.

(2) The Covered Person's Primary Care Physician will be responsible for coordinating Covered Services and making referrals to other Participating Providers. A Covered Person does not need a referral from his/her Primary Care Physician for obstetrical or gynecological treatment from a Participating Provider. A Covered Person may seek care directly from an obstetrician or gynecologist that is a Participating Provider. For all other Providers, the Covered Person must obtain a referral from his/her Primary Care Physician to obtain benefits for Covered Services under this Contract.

(3) You may change the selection of a Primary care Physician no more frequently than once each month. A Covered Person may change his/her Primary Care Physician by submitting a written request, online at [insert website address], or by contacting us at the number shown on your Identification Card. A change in Primary Care Physician selection will be effective no later than thirty (30) days from the date we receive a request.

ARTICLE 7. REQUESTING APPROVAL FOR COVERED SERVICES.

This Article 7 sets forth the procedures for requesting approvals for Covered Services from us as well as the ***claim review procedures for benefit determinations adverse to you***. In processing claims, we review requests for Precertification, Predetermination, and Post Service Clinical Claims Review to determine whether provided or proposed to be provided Health Care Services are Covered Services. Health Care Services must be Medically Necessary for Health Care Services to be considered Covered Services.

A. Covered Service Review Requests

(1) Types of Covered Service Review Requests.

(a) Precertification – 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.

(b) Predetermination – An optional, voluntary prior or concurrent request for a benefit coverage determination for a Health Care Service. We will review your Contract to determine if there is an Exclusion for the service or treatment requested. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service or treatment meets our definition of Medical Necessity, or if it is Experimental/Investigative as that term is defined in this Contract.

(c) Post Service Clinical Claims Review – A retrospective review (Post-Service) for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Precertification and did not undergo a Predetermination review. Post Service Clinical Claims Reviews are done for Health Care Services for which we have a related clinical coverage guideline and are typically initiated by us.

(2) Most Participating Providers know which Health Care Services require Precertification and will get Precertification or ask for Predetermination from us as needed. Your Primary Care Physician and all other Participating Providers have received information from us on the procedures for requesting approvals for Covered Services and are responsible for meeting the requirements under such procedures. Generally, the Participating Provider ordering the service, treatment or admission will contact us to ask for Precertification or Predetermination reviews ("Requesting Provider"). We will work directly with your Requesting Provider regarding such review requests; however, your Designated Representative may act on your behalf throughout the review process.

(3) We will utilize our clinical coverage guidelines, including internally developed guidelines, procedures, and preventative care clinical coverage guidelines, to help us determine whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions Identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

(4) You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact us at [toll free number].

B. Review Request Categories.

(1) Urgent Care – A request for Precertification or Predetermination that in the view of your attending Provider, or any physician with knowledge of your medical condition, could seriously jeopardize your life or health or your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Urgent Care Claim.

(2) Pre-Service – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

(3) Concurrent Care – A request for Precertification or Predetermination that is conducted during an ongoing course of treatment or admission. If we have approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by us of such course of treatment before the end of such period of time or number of treatments shall constitute a benefit determination adverse to you. We will notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination before the benefit is reduced or terminated.

(4) Post-Service – A request for approval that is made after the service, treatment or admission has occurred. Post-Service review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

C. Benefit Decision and Notice Requirements.

(1) We will resolve benefit review requests according to the timeframes listed in the table below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws.

Request Categories	**Timeframe Requirement for Benefit Decisions and Notification**
Pre-Service Claim	15 calendar days from receipt of request
Pre-Service Urgent Care Claim	72 hours from receipt of request
Concurrent Care Claim	15 calendar days from receipt of request
Concurrent Urgent Care Claim	24 hours from receipt of request

Post-Service Claim	20 business days from receipt of request

D. Timeframe Extensions for Benefit Decisions and Notifications.

(1) Post-Service and Pre-Service Claims. If we are unable to complete our review due to circumstances beyond our control, we will notify you, your Designated Representative, and the Requesting Provider in writing within:

(a) Fourteen (14) days after our receipt of a Pre-Service claim review request, and

(b) Nineteen (19) days after our receipt of a Post-Service claim review request.

The written notice will include the reason for the delay, a list of any applicable additional information that we need from you in order to complete our review and a revised timeframe for the resolution. If the reason for the delay is because your review request lacked sufficient information to complete our review of your request, you, your Designated Representative and Requesting Provider will have forty-five (45) days from receiving our notice of delay to provide the necessary information. We will notify you, your Designated Representative and the Requesting Provider of our decision within not more than ten (10) days after notifying you, your Designated Representative and Requesting Provider of the reason for our delay or of our receipt of the necessary information or of the end of the period afforded to you to supply the necessary information, as applicable. If we do not get the specific information we need or if the information is not complete by the timeframe provided to you, we will make a decision based upon the information we have.

(2) Urgent Care Claims. If you fail to provide us with sufficient information to review your Urgent Care Claim review request, we will notify you as soon as possible, but not later than twenty-four (24) hours after our receipt of the claim, of the specific information necessary to complete our review. You will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. We will notify you, your Designated Representative and Requesting Provider of our decision as soon as possible, but in no case later than forty-eight (48) hours of the earlier of the following:

(a) our receipt of the necessary information, or

(b) the end of the period afforded to you to supply the necessary information.

If we do not get the specific information we need or if the information is not complete by the timeframe provided to you, we will make a decision based upon the information we have.

E. Denial of Experimental Treatment.

If we deny coverage for a treatment, procedure, drug or device on the grounds that the treatment, procedure, drug or device is experimental, we will provide you with a written explanation that includes the following information:

(a) The basis for the denial.

(b) Your right to Appeal our decision.

(c) Our telephone number that you may contact for assistance in initiating an Appeal of our decision.

(2) If your health situation is life threatening or is an emergency, you are entitled to a review of our decision to deny coverage on the grounds that the treatment, procedure, drug or device is experimental that takes not more than seventy-two (72) hours.

F. Benefit Decision Appeals

(3) Your Right to Appeal. If you or your Requesting Provider disagrees with our decision regarding your benefit review request you or your Designated Representative may initiate an Appeal by contacting us either in writing and/or by phone at the address and phone number provided below.

[Address]

Your Appeal must be initiated within 180 days of receiving our decision regarding your benefit review request. We will acknowledge your Appeal within 3 business days of our receipt of your Appeal Request.

(4) Appeal Panel. We will appoint a panel of qualified individuals to resolve your Appeal (the "Appeal Panel"). We will ensure that no individual is appointed to the Appeal Panel who was involved in the matter giving rise to the compliant or in the initial investigation of the complaint.

(a) If the decision on Appeal involves the proposal, refusal or delivery of a Health Care Service the Appeal Panel will include at least one individual who:

(a) Has knowledge in the medical condition and Health Care Service;

(b) Is in the same licensed profession as the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint; and

(c) Is not involved, in any manner, in the matter that is the basis of the underlying complaint or has a direct business relationship with you or the Provider who proposed, refused, or delivered the Health Care Service that is the basis of the underlying complaint.

(b) The Appeal Panel shall resolve the Appeal as expeditiously as possible and with regard to the clinical urgency of the Appeal. We shall set a date

and place during normal business hours for the Appeal Panel to meet to discuss your Appeal. You will be given seventy-two (72) hours advance notice of the date and time of the meeting. You or your Designated Representative may appear in person at the Appeal Panel meeting or communicate with the Appeal Panel through appropriate other means if you or your Designated Representative are unable to appear in person.

(5) Timeframe for Resolution of Appeals. The Appeal Panel will resolve Appeals according to the timeframes listed in the table below.

Appeal Categories	**Timeframe Requirement for Appeal Decisions and Notification**
Appeal of a Pre-Service Claim Decision	30 calendar days from our receipt of the Appeal
Appeal of a Pre-Service Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Concurrent Care Claim Decision	15 calendar days from our receipt of the Appeal
Appeal of a Concurrent Urgent Care Claim Decision	Referred directly to an internal expedited review process (See "Expedited Review of Internal Appeals")
Appeal of a Post-Service Claim Decision	45 calendar days from our receipt of the Appeal

We shall notify you or your Designated Representative of our decision in writing regarding your Appeal within five (5) business days after we complete our investigation.

(6) Expedited Review of Internal Appeals.

(a) An Expedited Review of an internal Appeal may be initiated orally, in writing or by other reasonable means available to you, your Designated Representative or your Provider.

(b) Expedited Review is available only if your attending Provider believes that, based upon your medical condition, our standard internal Appeal procedure could seriously jeopardize your life or health or your ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed.

(c) Appeals of Urgent Care Claim decisions are referred directly to our Expedited Review procedure for investigation and resolution.

(d) We will complete our Expedited Review of your Appeal as soon as possible given the medical exigencies but no later than within 72 hours after our receipt of your request for Appeal.

(e) We will communicate our decision regarding your Appeal by telephone to you, your Designated Representative, and your attending Provider. We will also provide written notice of our decision to you, your Designated Representative and your attending Provider.

(f) An Expedited Review of Concurrent Urgent Care Claims and Pre-Service Urgent Care Claims may occur at the same time as an External Review (as described below).

G. External Review

(1) You or your Designated Representative may seek External Review if our decision regarding your Appeal upheld a decision that was adverse to you regarding any of the following.

(a) A Medically Necessary service.

(b) A utilization review decision.

(c) A determination that a proposed service is Experimental/Investigational.

(d) A decision to rescind your Contract.

If your Appeal did not involve one of the above adverse decisions, you are not entitled to an External Review.

(2) If you have the right to an External Review under Medicare (42 U.S.C. 1395, et seq.) you may not request an External Review of our Appeals decision under the procedures outlined in this Contract.

(3) If your situation qualifies, you or your Designated Representative must file a written request for an External Review with us within 120 days after you receive notice of our internal response to the Appeal.

(4) Independent Review Organization (IRO).

(a) If an External Review is requested, we will forward all information related to your External Review to an IRO selected from the list of IROs that are certified by the Indiana Department of Insurance.

(b) The IRO will make a determination to uphold or reverse our Appeal decision within seventy-two (72) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within fifteen (15) business days if the condition does not involve an Urgent Care Claim.

(c) The IRO will notify you and your Designated Representative of its decision within twenty-four (24) hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within seventy-two (72) hours if the review does not involve an Urgent Care Claim.

(d) If the IRO decision reverses our Appeals decision, we will notify you, your Designated Representative or Provider in writing of the steps we will take to comply with the Iron's decision.

H. Important Contact Information and Notice to Covered Persons

(1) Questions regarding your coverage should be directed to: [Indiana University Health Plans]; [toll free number]

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

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

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

Complaints can also be filed electronically at www.in.gov/Idoi.

ARTICLE 8. PAYMENT FOR COVERED SERVICES

A. How to Obtain Benefits.

(1) Whenever you receive Health Care Services, you must provide the Provider with a copy of your Identification Card.

(2) When you receive Covered Services from a Participating Provider you are not required to file a claim. Since no claim filing is required, you are not required to follow the procedures outlined in Section C of this Article 8.

B. Who Receives Payment Under This Contract.

(1) We pay Benefits for your Covered Services directly to a Participating Provider.

(2) If you receive Covered Services from a Non-Participating Provider as provided in Article 6 Section B, we will pay Benefits to the Non-Participating Provider, unless you agreed to make payment to the Non-Participating Provider and are entitled to reimbursement for such payment.

C. Payment for Covered Services received from Non-Participating Providers.

(1) Time to File Claims. For Covered Services received from a Non-Participating Provider, written notice of a claim must be given to us, by you or the Non-Participating Provider, within thirty (30) days of the date the Covered Services began. Failure to furnish the claim within thirty (30) days will not invalidate or reduce any claim if submission within thirty (30) days was not reasonably possible, so long as the claim is submitted within a reasonable time.

(2) Claim Forms. We shall provide forms to you for filing Proof of Loss within fifteen (15) days of notice of any claim. If you do not receive the forms within fifteen (15) days, written notice of services rendered may be submitted to us without the claim form. Claim forms are available on our website at [website address].

(3) Proof of Loss. Proof of loss under this Contract must be furnished to us within ninety (90) days after the loss. Failure to furnish the claim within ninety (90) days will not invalidate or reduce any claim if submission within ninety (90) days after the loss was not reasonably possible, so long as the claim is submitted within one (1) year after the time required under this Contract unless you were legally incapacitated.

(4) Address. All correspondence regarding claims should be sent to us at:

[Indiana University Health Plans]
[Address]
[City/state/zip]
[Fax]

(5) Amount of Payment. Payment for Health Care Services received from a Non-Participating Provider will be the lesser of the following amounts.

(a) The usual, customary and reasonable charge for the Health Care Service;

(b) An amount agreed upon by us and the Non-Participating Provider.

D. Clean Claims.

(1) A clean claim is a claim submitted by a Provider for payment that has no defect. We shall pay or deny each clean claim as follows.

(a) If the claim is filed electronically, within thirty (30) days after the date we receive the claim.

(b) If the claim is filed on paper, within forty-five (45) days after the date we receive the claim.

(2) If we fail to pay or deny a clean claim in the time frames set forth above and subsequently pay the claim, we will pay the Provider that submitted the claim allowable interest in accordance with Indiana Code § 27-8-5.7-6.

ARTICLE 9. COORDINATION OF BENEFITS

This Article applies only if you also have other health benefits coverage with another Plan. The Definitions contained in this Article apply throughout this Article 9 but do not apply to the rest of the Contract.

A. **When you have other health benefits**. In the event that you are covered by two health insurance contracts, plans or policies ("Plans") providing similar benefits and you receive a Health Care Service that would be covered by both Plans, we will coordinate benefit payments with any payment made under the other Plan. One company will pay its full benefit as the Primary Plan. The other company will pay Secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments.

B. **Definitions**.

(1) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the Plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(2) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

(3) "Closed Panel Plan" means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in the case of emergency or referral by a panel Covered Person.

(4) "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(5) "Plan" means any of the following that provides benefits or services for medical treatment:

(a) Any group or blanket insurance contract, plan or contract, except that blanket school accident coverage or such coverage offered to

substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or contract.

(b) Any self-insured or noninsured Plan or any other Plan arranged through an employer, trustee, union, employer organization or employee benefit organization.

(c) Any coverage under governmental programs or any coverage required to be provided by any statute. However, Medicaid and any Plan whose benefits are, by law, excess to those of any private insurance plan or other nongovernmental plan shall not be considered health insurance policies.

(d) Group or nongroup coverage through Closed Panel Plans or group type contracts.

(e) Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional "fault" type contracts.

(6) "Primary" or "Primary Plan" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If the Plan is Primary to another Plan, the Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(7) "Secondary" or "Secondary Plan" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If the Plan is Secondary to another Plan, the Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

C. Rules To Determine Payment. When two or more Plans pay benefits, the rules for determining the order of payments are as follows:

(1) The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

(2) If the other Plan does not have a provision similar to this one, then it will be primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(3) A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. Order of Determination of Benefits Rules: The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent is Primary, for example as an employee, subscriber or retiree is

primary and the Plan that covers the person as a Dependent is Secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent; then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, subscriber or retiree is Secondary and the other Plan is Primary.

(2) Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

(a) The parents are married;

(b) The parents are not separated (whether or not they ever have been married); or

(c) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods commencing after the Plan is given notice of the court decree.

(d) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(a) The Plan of the Custodial Parent.

(b) The Plan of the spouse of the Custodial Parent.

(c) The Plan of the non-Custodial Parent.

(d) The Plan of the spouse of the non-Custodial Parent.

(3) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is Primary. The same would hold true is a person is a Dependent of a person covered as a retiree or an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined Section (C)(1) of this Article 9.

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, subscriber or retiree (or as that person's Dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, subscriber or retiree longer is Primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid if it had been Primary.

E. Payment of the Benefit When This Plan is Secondary.

(1) When this Plan is Secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other Plan and this Plan do not exceed your expenses for an item of service. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by the Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

(a) Determine its obligation to pay or provide benefits under its Plan;

(b) Determine whether a benefit reserve has been recorded for the Covered Person; and

(c) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

(2) If there is a benefit reserve, the Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

(3) If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, Coordination of Benefits shall not apply between that Plan and other Closed Panel Plans.

F. Payments to others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid.

G. Our Right to Recover Overpayment. In some cases, we may have made payment even though you had coverage under another Plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the

payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other Plan. You agree to sign any document that we deem necessary to help us recover any overpayment.

ARTICLE 10. TERMINATION OF COVERAGE

A. [**Guaranteed Renewable.** As long as you continue to be a Qualified Individual and this Contract continues to be a Qualified Health Plan, you may renew this Contract at your option without regard to the health status of you or any Covered Person.]

[Guaranteed Renewable. Coverage under this Contract is guaranteed renewable at the discretion of the Subscriber, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, as described in this Article 10. You may renew this Contract at your option without regard to the health status of you or any Covered Person. You may renew this Contract by payment of the renewal premium by the end of the Grace Period of the premium due date, provided the following requirements are satisfied:

(1) Eligibility criteria outlined in Article 2 continues to be met.

(2) There are no fraudulent or intentional misrepresentations on the application or under the terms of this Contract.

(3) Coverage has not been terminated by us under the terms of this Contract.]

B. **Termination.** We may terminate this Contract or coverage of a Covered Person for the following reasons.

(1) You are no longer eligible for coverage [through the Indiana Marketplace].

(2) A Covered Person is no longer eligible under [the rules of the Indiana Marketplace or] the terms of this Contract.

(3) You do not pay premium and the applicable Grace Period has been exhausted.

(4) We receive a request from you to terminate the Contract.

(5) You commit an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact.

(6) You change coverage to another [Qualified Health Plan] [health plan] during the [Indiana Marketplace] Open Enrollment Period or a Special Enrollment Period.

(7) [The Contract is no longer a Qualified Health Plan or we are decertified by the Indiana Marketplace.]

(8) You no longer reside in our Service Area.

(9) We discontinue a particular product provided that we provide you with written notice at least ninety (90) days before the date the product will be discontinued, we offer you the option to purchase any other individual contract we currently offer, and we act uniformly without regard to any health status-related factor.

(10) We discontinue all contracts in the individual market in Indiana provided that we provide you and the Indiana Department of Insurance with written notice at least

180 days before the date of the discontinuance, we discontinue and do not renew all contracts in the individual market in the State of Indiana, and we act uniformly without regard to any health status-related factor.

(11) We may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with the laws of the State of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

C. Effective Date of Termination. [Termination of this Contract automatically terminates all coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.]

(1) If you terminate this Contract or coverage for a Covered Person, the last day of coverage [will be on the last day of the billing period for which premium has been paid. A request for termination must be received by us in writing] [is:

(a) The termination date specified by you, if reasonable notice is provided;

(b) If you do not provide reasonable notice, fourteen (14) days after the termination is requested, or

(c) If you do not provide reasonable notice and request a termination date in less than fourteen (14) days, on a date determined by us if we are able to implement termination in fewer than fourteen (14) days.]

(2) [If newly eligible for Medicaid, the Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.]

(3) [If you are no longer eligible for coverage through the Indiana Marketplace, the last day of coverage is the last day of the month following the date notice is sent to us by the Indiana Marketplace, unless you request an earlier termination effective date.] [If you move outside of the Service Area, the last day of coverage for you and all of your Dependents will be at the end of the billing period that contains the date you no longer resided in the Service Area.]

(4) [If a Covered Person is no longer eligible for coverage under the rules of the Indiana Marketplace or the terms of this Contact, the last day of coverage is the last day of the month following the date the Covered Person loses eligibility.] [If a Dependent no longer meets the definition of Dependent, the last day of coverage for the Dependent will be on the last day of the billing period in which we received notice of the Dependents loss of eligibility.]

(5) In the case of a termination for non-payment of premium and the applicable Grace Period has been exhausted, the last day of coverage [for all Covered Persons] will [be either the last day of the first month of the 3-month Grace Period or] the last day for which premium was paid.

(6) [In the case of a termination due to a change to another Qualified Health Plan, the last day of coverage is the day before the effective date of coverage in his or her new Qualified Health Plan.]

(7) The day following a Covered Person's death. When a Subscriber dies, the surviving spouse, if covered under the Contract, may receive an individual contract. The surviving spouse should contact [the Indiana Marketplace] [us] to identify the process for enrollment.

D. Notice of Termination.

(1) We shall provide you with written notice of our intent to terminate or not renew this Contract at least sixty (60) days prior to the effective date of the termination. This notice will identify the date upon which your coverage will terminate.

(2) Our notice to the Subscriber shall be deemed as notice to all Covered Persons and is sufficient if mailed to the Subscriber's address as it appears in our records.

(3) Termination of this Contract shall not prejudice any claim for Covered Services rendered before the effective date of the termination.

E. Continuation of Coverage.

(1) If we terminate this Contract, except for a termination due to our receivership, and a Covered Person is hospitalized for a medical or surgical condition on the effective date of the termination, coverage will continue for Inpatient Covered Services. Benefits shall end on the earliest of the following dates.

(a) The date the Covered Person is discharged from the Hospital.

(b) The date the Covered Person is covered under other health coverage if that coverage covers the Inpatient Hospital services.

(c) Sixty (60) days after the date this Contract ends.

(d) The last day the required premium has been paid if the Grace Period expires and the Subscriber has not made the required payment.

(e) The date the you terminate coverage.

(2) If this Contract terminates due to our receivership, coverage will continue for the following time period:

(a) The duration of the contract period for which premiums have been paid.

(b) If a Covered Person is hospitalized on the date of our receivership for the longer of the following time periods.

(A) The period ending when the Covered Person is discharged from the Inpatient hospitalization.

(B) The duration of the contract period for which premiums have been paid.

F. Rescission. If within two (2) years after the Effective Date of this Contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or a Covered Person did not disclose on your application, we may rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding your newly born children within 31 days of birth), we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or a Covered Person did not disclose on the application, we may rescind coverage for the additional Dependent as of his or her original Effective Date. Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by a Covered Person may result in termination or rescission of coverage. You are responsible to pay us for the cost of previously received services based on the Allowed Amount for such services, less any Copayments/Coinsurance paid or Premium paid for such services.

This Contract may also be terminated if you knowingly participate in or permit fraud of deception by any Provider, vendor or any other person associated with this Contract. Termination for any act, practice or omission that constituted fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give you at least thirty (30) days written notice prior to the rescission of this Contract.

G. Reinstatement. If your Contract was terminated for non-payment of premium, you may request reinstatement of the Contract from [the Indiana Marketplace] [us] within 30 days of the effective date of the termination. You must remit all premium that was due for the coverage upon reinstatement. Upon [notice from the Indiana Marketplace and] receipt of the outstanding premium, we will reinstate coverage as of the effective date of the termination.

H. [**Certification of Prior Creditable Coverage If Required by Law.** If your coverage is terminated, you and your Dependents will receive certification from us showing that you were covered under this Contract. You may need this certification document in order to purchase, for yourself and/or your family, other health coverage. Certifications may be requested within twenty-four (24) months of losing coverage.

You may also request certification be provided to you at any other time, even if you have not lost your coverage under this Contract. If you have any other questions regarding certification of creditable coverage, contact the Customer Service telephone number on the back of your Identification Card.]

ARTICLE 11. GRIEVANCE PROCEDURES

The Grievance procedures provided in this Article 11 are established and maintained by us for the filing, investigating, and resolving of Grievances and Appeals that are ***unrelated to benefit decisions*** that are adverse to you. ***For procedures applicable to benefit decisions please refer to Article 7 of this Contract.***

A. **What is a Grievance**. A Grievance is any dissatisfaction expressed by you or on your behalf regarding any of the following for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(1) Availability, delivery, appropriateness, or quality of health care services.

(2) Handling or payment of claims for health care services.

(3) Matters pertaining to the contractual relationship between you and us.

B. **Who May File.**

(1) You have the right to designate a representative to act on your behalf throughout the Grievance and Appeals process. You, or your Designated Representative acting on your behalf, may file a Grievance with us. Your Designated Representative may also represent you throughout the Grievance procedure.

(2) If our decision regarding your Grievance is adverse to you, you or your Designated Representative may file an Appeal of that decision with us, and your Designated Representative may represent you throughout the Appeals procedure.

C. **How a Grievance May Be Filed.**

(1) You or your Designated Representative may file a Grievance with us either orally, including by telephone, or in writing, including by electronic means at the following address.

[Address, including fax]

(2) A Grievance is considered to be filed with us on the day and time it is first received by us whether orally or in writing.

D. **No Retaliation**. Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this Article 10 or Article 7. We may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this Article 10 or Article 7.

E. **Grievance Procedure**.

(1) Filing Process. In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. Upon our receipt of your written or oral Grievance, we will acknowledge your Grievance, orally or in

writing, within three (3) business days of our receipt of it. We will document the substance of the Grievance and any actions taken.

(2) Review. Qualified personnel will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it.

(3) Decision. Our decision regarding your Grievance must be made as soon as possible, but no later than twenty (20) business days after your Grievance was filed.

(4) Delay. If we are not able to make a decision by the twentieth (20th) business day due to reasons beyond our control we will notify you in writing of the reason for the delay before the twenty (20) business day period expires; and notify you, in writing, of our decision within an additional ten (10) days.

(5) Notice of Decision. Within five (5) business days after completing our investigation, we will send you written notice of our resolution of your Grievance.

F. Appeals Procedure.

(1) Right to an Appeal.

(a) If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us.

(b) You or your Designated Representative must submit the Appeal to us within 180 days of our decision regarding your Grievance.

(c) The Appeal may be expressed orally or in writing.

(d) We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will document the substance of the Appeal and the actions taken.

(2) Appeal Panel.

(a) Our Appeal Panel (the "Appeal Panel") will resolve the Appeal. The Appeal Panel shall be comprised of qualified individuals who were not involved in the investigation or resolution of the underlying Grievance or involved in the matters giving rise to it.

(b) You or Your Designated Representative may:

(a) appear in person before the Appeal Panel; or

(b) communicate with the Appeal Panel through other appropriate means, if unable to attend in person.

(c) You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

(d) To support your Appeal, you should submit to the Appeal Panel any written issues, arguments, comments, or other documented evidence.

(e) The Appeal Panel shall review all findings and pertinent documents, whether or not we have considered them previously. The Appeal Panel will not afford any special deference to the original denial of your Grievance.

(3) Appeal Decision and Notice of Decision.

(a) The Appeal Panel's decision regarding Your Appeal will be made as soon as possible, but not later than forty-five (45) days after the Appeal was filed.

(b) We will notify you in writing of the Appeal Panel's decision within five (5) business days after it is decided.

G. Notice to Covered Persons.

(1) If you have questions regarding your rights under this Contract or if you need Assistance, please contact us at:

[Indiana University Health Plans]
[toll free number]

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

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

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

Complaints can be filed electronically at www.in.gov/Idoi.

(3) The review procedures described in this Article 11 do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

ARTICLE 12. GENERAL PROVISIONS

A. **Entire Contract**. This Contract, the Schedule of Benefits, and any application, rider or amendment(s) make up the entire agreement between you and us as of the Effective Date and supersede all other agreements. All statements made by you shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce coverage under this Contract or be used in defense of a legal action unless it is contained in the application.

B. **No Assignment**. The benefits provided under this Contract are for your and your enrolled Dependents' personal benefit. You may not assign any of your rights to coverage. Any attempt by you to assign this Contract to any third party is void. Provided, however, that subject to our right to disapprove, you may assign your right to reimbursement for Covered Services to the Provider who provided such Covered Services.

C. **Notice**. Any notice that we give to you under this Contract will be mailed to your address as it appears on our records. Our notice to the Subscriber is deemed notice to all enrolled Dependents. Notice is deemed delivered three (3) calendar days after its deposit in the United State Mail with first class postage prepaid unless otherwise stated in this Contract. If you have to give us any notice, it should be mailed to:

[Indiana University Health Plans, Inc.]
950 North Meridian Street, Suite 200
Indianapolis, Indiana 46204

D. **Relationship Between Parties**. The relationships between us and Participating Providers are *solely* contractual relationships between a payor and independent contractors. Non-Participating Providers have no contractual relationship with us, nor are they our independent contractors. Providers are not our agents or employees. We and our employees are not employees or agents of Providers. The relationship between a Provider and any Covered Person is that of Provider and patient. The Provider is *solely* responsible for the services provided to any Covered Person.

E. **Disagreement with Recommended Treatment.** Each Covered Person enrolls in this Contract with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate Health Care Services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice. If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, the Provider and we, as applicable, may determine that neither this Contract nor the Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of this Contract for the condition under treatment or any complications thereof.

F. **Your Medical Records**. As a condition precedent to the approval of claims hereunder, each Covered Person authorizes and directs any Provider that furnishes benefits hereunder to make available to us information relating to all Health Care Services, copies thereof and other records as needed by us for purposes of administering this Contract. In every case we will hold such information and records as confidential in accordance with state and federal confidentiality requirements.

G. **Second Opinion Policy**. A second opinion may be required at our discretion prior to the scheduling of certain Covered Services. We will advise you if a proposed Covered Service is subject to the second opinion policy. If so, you must consult with a second Participating Provider prior to the scheduling of the service. You must (a) contact us to obtain a list of Participating Providers who are authorized to render a second opinion, and (b) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider. You must obtain the second opinion within thirty-one (31) days of the first opinion or as soon thereafter as is reasonably possible. Second opinions we have arranged as described above are provided at no cost to you. A second opinion may also be obtained at the request of a Covered Person, subject to separate benefit restrictions and/or Copayments or Coinsurance described in this Contract.

H. **Who May Change This Contract**. This Contract may not be modified, amended or changed, except in writing, and signed by one of our officers. No employee, agent or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage or the conditions of eligibility, enrollment or participation unless in writing and signed by one of our officers. We are not bound by any verbal statements. We will provide you with written notice of any material modification to this Contract not later than sixty (60) days prior to the date on which such material modification will become effective.

I. **Renewal Date**. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date for the term set forth in the Contract unless otherwise terminated by us as permitted by the Contract or by you upon thirty (30) days' prior written notice.

J. **Identification Cards**. Identification Cards are issued by us for identification only. Possession of any Identification Card confers no right to services or benefits under this Contract. To be entitled to such services or benefits the Covered Person's premiums must be paid in full at the time the Health Care Services are sought to be received. Coverage under this Contract may be terminated by us if the Covered Person allows another person to wrongfully use the Identification Cards.

K. **Right to Develop Guidelines and Administrative Rules**. We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Contract. An example of the use of the standards is to determine whether care was Medically Necessary. These standards will not be contrary to the descriptions in this Contract. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Contract.

L. **Non-Discrimination**. In compliance with state and federal law, we shall not discriminate on the basis of age; gender; color; race; disability; marital status; sexual preference; religious affiliation; or public assistance status. We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care. We shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew Coverage, (b) cancel coverage, (c) limit Benefits, or (d) charge a different premium. We shall not discriminate against victims of abuse in compliance with Indiana Code Sec. 27-8-24.3-1.

M. **Incontestability**. The validity of the Contract may not be contested after two (2) years, except for nonpayment of premiums or if the disputed statement is in a written instrument signed by the Subscriber. The ineligibility of the Subscriber or a Dependent under the Contract may be disputed at any time.

N. **Limitation of Action**. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Contract and within three (3) years from the date the Health Care Services were received. The Subscriber's damages shall be limited to recovery of actual Benefits due under the terms of this Contract. The Covered Person waives any right to recover any additional amounts or damages including, but not limited to, punitive and/or exemplary damages.

O. **Examination of Covered Persons**. We may reasonably require that you be examined if a question or dispute about the provision of or payment for Covered Services arises. The exam will be performed by a Participating Provider acceptable to us. We will pay for the exam.

P. **Right of Recovery.** If we pay for Health Care Services that, according to the terms of the Contract, should not have been paid, we reserve the right to recover such amounts from whom they have been paid (including the Covered Person or Provider) or any other appropriate party.

Q. **Contract is not a Medicare supplement policy**. Any Covered Services that are covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare, we will calculate benefits as if they had enrolled. The benefits under this Contract for Covered Persons age 65 and older or Covered Persons otherwise eligible for Medicare do not duplicate any benefit for which Covered Persons are entitled under Medicare, except when federal law requires us to be Primary. Where Medicare is Primary, all sums payable by Medicare for Health Care Services provided to Covered Persons shall be reimbursed by or on behalf of the Covered Persons to us to the extent we have made payment for such Health Care Services.

R. **Contract is Not Worker's Compensation Insurance**. The coverage provided under this Contract does not replace, supplement or provide a substitute for benefits to which a

Covered Person is entitled under worker's compensation, occupational disease, and similar laws. The Contract does not cover Health Care Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's compensation, occupational disease and similar laws, even when the circumstances below are present.

(1) If the Covered Person's employer is not properly insured or self-insured under such laws.

(2) When a Covered Person refuses to use his or her employer's designated Provider.

(3) When a Covered Person has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

A Covered Person must contact his employer or its worker's compensation or occupational disease insurer for the provision or payment of such Health Care Services.

S. General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within our control we will pay benefits for Covered Services as provided in this Contract to the extent that facilities and personnel are then available, and we shall have no liability or obligation for delay or failure to provide Covered Services due to lack of available facilities or personnel.

T. Typographical or Administrative Error. Typographical or administrative errors shall not deprive a Covered Person of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

U. Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on the Effective Date shall apply. Any Contract provision which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

V. Governing Law. This Contract will be subject to the laws of the state of Indiana.

W. Severability. In the event that any provision in the Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

[Schedule of Benefits]

Actuarial Memorandum

Indiana University Health Plans, Inc.

Individual Health Rate Filing

Effective January 1, 2015 through December 31, 2015

Form: 13164.1-Indiv-Policy-Adult (01/2015)

13164.1-Indiv-Policy-Child (01/2015)

Submitted: May 9, 2014

TABLE OF CONTENTS

1) General Information 3
2) Proposed Rate Increase(s) 4
3) Experience Period Premium and Claims 4
4) Benefit Categories 5
5) Projection Factors 5
6) Credibility Manual Rate Development 5
7) Credibility of Experience 7
8) Paid to Allowed Ratio 7
9) Risk Adjustment and Reinsurance 8
10) Non-Benefit Expenses and Profit & Risk 8
11) Projected Loss Ratio 9
12) Single Risk Pool 10
13) Index Rate 10
14) Market Adjusted Index Rate 10
15) Plan Adjusted Index Rates 11
16) Calibration 12
17) Consumer Adjusted Premium Rate Development 12
18) AV Metal Values 13
19) AV Pricing Values 13
20) Membership Projections 13
21) Terminated Products 14
22) Plan Type 14
23) Warning Alerts 14
24) Company Financial Position 14
25) Reliance 14
26) Actuarial Certification 15

1) General Information

Overview

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template (URRT), which supports compliance with the market rating rules and reasonableness of applicable rate increases.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with State of Indiana statutes and provisions of the Affordable Care Act (ACA). This memorandum documents the development of the Individual rates for Indiana University Health Plans, Inc. (IUHP). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This information may not be appropriate for other purposes.

This information is intended for use by the State of Indiana Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of IUHP's Individual rate filing. However, we recognize that this certification may become a public document. PwC makes no representations or warranties regarding the contents of this memorandum to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum prepared for IUHP by PwC that would result in the creation of any duty or liability under any theory of law by PwC or its employees to third parties.

These results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

Company Identifying Information

- Company Legal Name: Indiana University Health Plans, Inc.
- State: The State of Indiana has regulatory authority over these policies
- HIOS Issuer ID: 33380
- Market: Individual
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: Eric Neuville, Vice President Product Development and Innovation
- Primary Contact Telephone Number: (317) 963-1835
- Primary Contact Email Address: eneuville@iuhealth.org

Certifying Actuary Contact Information

- Primary Contact Name: Robert Macagnano, PwC
- Primary Contact Telephone Number: (973) 236-4082
- Primary Contact Email Address: robert.macagnano@us.pwc.com

Benefit Summary

IUHP will be offering three Bronze, three Silver, and one Gold HMO products. A summary of the major provisions of each plan are provided in Appendix A.

Premium Guarantee Provision

Premiums are guaranteed not to change through December 31, 2015.

Renewability

The policy is renewable by paying the applicable renewal premiums unless the policyholder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability

The rates will apply to new business. Subsequent renewal business will be subject to rates filed for our 2016 rate development.

Premium Modalization

Premiums will be collected only on a monthly basis.

Trend Assumption

Rates are effective for calendar year 2015. Trend assumptions will be developed for future rating periods based on developing experience, and anticipated changes in provider reimbursement.

2) Proposed Rate Increase(s)

This is a new filing therefore no rate increase assumption is included in this filing. Subsequent rate increases beginning with effective dates of January 1, 2016 will be filed in the future.

3) Experience Period Premium and Claims

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

4) Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.

Capitation: Includes capitated services for pediatric vision benefits.

Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

5) Projection Factors

Not applicable. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

6) Credibility Manual Rate Development

The PwC Rating Model was used as the basis to develop the manual rates. Our model was developed using two primary sources:

- Commercial Truven Health MarketScan® Research Databases for U.S. members and providers. The database contains full enrollment and claims information with standard medical coding which allows for cost and utilization information by service category (inpatient, outpatient hospital, hospice, home health, professional, prescription drugs, etc.). The database consists of the experience from 53 million Commercial eligible participants. The data can be extracted down to the member's state and MSA level. For the Indiana Commercial market, there were approximately 1.5 million exposed life years' worth of data crossing all ages, genders and employment statuses (active, COBRA, disabled and retired). Nationwide, the databases have over 100 unique data contributors so it is not skewed to any one payer.
- OptumInsight (Optum) Comprehensive Pricing Model® provides benchmark data and pricing capabilities for Commercial health plans. It factors in health plan features such as

deductibles, copays, out-of-pocket maximums, covered services, etc. The model uses normative data and benefit details to arrive at an allowed cost per member per month. The normative benchmarking utilization metrics within the model are developed from Optum's database of Commercial (under 65) health plan experience of approximately 20 million life years. The model experience was adjusted to reflect the Indiana marketplace.

Since both the Truven and Optum data sources represent fully-completed calendar year 2012 claims, allowed costs were trended to the midpoint of calendar year 2015 using an annual trend rate of 7.4%.

The allowed costs component of the manual rates was increased by 2% to account for expected changes in covered benefits due to the Essential Health Benefits (EHB) requirements. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- State mandated benefits included in the EHB that previously only applied to group coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

The manual rates were increased by 15% to reflect the entrance of approximately 7,000 Medicaid Spend-Down beneficiaries into the Indiana Health Insurance Exchange. This adjustment was based on the assumption that IUHP's penetration of the Medicaid Spend-Down population would be similar to their assumed penetration of the general population. Expenditure information for the Medicaid Spend-Down population was provided by the Indiana Family and Social Services Administration and contained in the April 21, 2014 study "Spend Down Exchange Impact: Transition to the Indiana Health Insurance Exchange" performed by Milliman, Inc. In addition, preliminary estimates provided by the Indiana Department of Insurance (IDOI) during their May 2, 2014 Weekly ACA Rate & Form Filing Call Session indicated that the inclusion of this population would increase premiums by 5% - 15%. We have been informed by the IDOI that additional information pertaining to this population will be made available. We reserve the right to revise our filing to reflect this data subsequent to this filing.

There will also be new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services. Pent up demand has been shown to increase costs in the first year of enrollment for those previously uninsured. Based on analysis of programs serving a similar population, it appears that the claims are higher in the first six to 12 months that an individual is newly insured. After this initial period, the claims experience tends to revert to the average level for the market. The total effect is uncertain and may be offset by some new enrollees having reduced utilization as they may not fully

understand new or increased coverage. Therefore, we have included an adjustment within our manual rate development for pent up demand of 5.0%.

The following adjustments were made to calibrate the pricing model to the expected population:

- Rating region
- Expected demographics
- Expected morbidity
- Contractual Agreements with healthcare providers
- Expected utilization management savings
- Benefit plan designs

Some benefits will be reimbursed under a capitation arrangement. The provider reimbursement adjustment to the pricing model was developed to account for the cost of capitated services.

The manual rates were also adjusted upward by a factor of 1.005 to account for the likelihood that some enrollees may not pay their premiums due during the first month of the 90-day grace period. This was calculated assuming a 15% rate of non-payment on one-twelfth of the annual premium due for 80% of the Individual population (those eligible for Advance Payments of a Premium Tax Credit). The amount of premium at risk is only on the portion that IUHP does not receive via direct subsidy, estimated to be 50% (0.15 x 1/12 x 0.80 x 0.50 = 0.005). The 15% represents our assumption regarding the small portion of enrollees that we believe will knowingly take advantage of the grace period provision. The 80% represents the portion of enrollees in the 2015 Individual marketplace that we assume will be eligible for premium subsidies based on income level. On May 1, 2014 the Department of Health and Human Services reported that as of April 19, 2014, 89% of those enrolled in the Indiana exchange were eligible for federal assistance. Our assumption is that this percentage will decrease during 2015.

7) Credibility of Experience

IUHP has not previously operated in the individual market. As a result the “Experience Period” section of Worksheet 1 of the URRT has not been populated. Similarly, the projection factors (cells J24:M29 on Worksheet 1) have also been left blank. The service category PMPMs shown in the “Credibility Manual” section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

8) Paid to Allowed Ratio

The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT calculates the PMPM costs on both an allowed and paid basis. The “Paid to Allowed Average Factor in Projection Period” shown on Worksheet 1, Section III of the URRT is developed by membership-weighted EHB paid claims divided by membership-weighted EHB allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

9) Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. At this time, IUHP is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value. Therefore, no risk adjustment PMPM payment is assumed for 2015.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only)

The Federal transitional reinsurance program is a temporary risk mitigation program expected to reduce costs for insurance issuers. The 2015 reinsurance program has an attachment point of $70,000 and a maximum coverage limit of $250,000 per member. The Department of Health and Human Services will reimburse insurance issuers 50% of paid costs between the attachment point and maximum coverage limit.

Allowed claims were reduced by 7.0% to account for the anticipated 2015 reimbursements from this temporary program. This estimate was developed using projected paid claims, a claims probability distribution calibrated to the expected average claim levels for the 2015 Individual market, and the federal program guidelines summarized above. The expected reinsurance reimbursements of $51.43 PMPM are allocated proportionally by plan based on allowed claims. Applying the 2015 transitional reinsurance charge of $3.67 PMPM yields a net reinsurance cost of $47.76 PMPM.

Projected Net Cost of Private Reinsurance

The projected net cost of private reinsurance for 2015 is $0.00 PMPM since IUHP does not intend to purchase private reinsurance.

10) Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

IUHP developed their expected administrative expenses based on: a) current administrative expenses for their Medicare line of business adjusting for any expected differences for their Commercial products, and b) a review of 2014 Rate Filings for Individual Exchange products. A summary of IUHP's assumptions is as follows:

- Administrative expenses (excluding Sales and Marketing expenses): 10.50% of premium
- Sales and Marketing expenses (including commissions): 3.70% of premium

These administrative expenses are allocated proportionally by plan.

Quality Improvement Expenses

At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. Therefore, no explicit Quality Improvement expenses were assumed.

Profit & Risk Margin

The proposed rates reflect a profit & risk margin of 3.0% of premium. This load was applied to all products and plans.

Taxes and Fees

A summary of the assumed taxes and fees are summarized below:

PMPM Basis

- Transitional reinsurance charge: $3.67 PMPM ($44.00 per member per year)
- Risk adjustment user fee: $0.08 PMPM
- PCORI fee: $0.17 PMPM ($2.00 per member per year)

Percentage of Premium Basis

- Health insurance exchange fee: 3.15% of premium reflecting IUHP's assumption that 90% of their expected 2015 business will be sold through the exchange
- ACA issuer fee: IUHP will not be subject to this fee for 2015
- Premium tax: 1.30% of premium

11) Projected Loss Ratio

The overall projected medical loss ratio for 2015 is 82.5%. This calculation excludes regulatory fees and taxes. At the time of this filing, IUHP was unable to determine the proportion of their administrative expenses attributable to approved Quality Improvement initiatives. As a result, we have not included an adjustment in the MLR calculation for these expenses. It is IUHP's intent to identify their Quality Improvement expenses for purposes of submitting their MLR-related filings and calculating related rebates, if any. The table below shows the calculation.

a)	Incurred Claims Net of Cost Sharing	$501.10
b)	Transitional Reinsurance Reimbursement	($51.43)
c)	Reinsurance Charge	$3.67
d)	Quality Improvement Expenses	$0.00
e)	Worksheet 1 Projected Incurred Claims (a+b+c+d)	$453.34
f)	Administrative Expenses	$82.21
g)	Profit & Risk Margin	$17.37
h)	Regulatory Taxes and Fees (excluding reinsurance charge)	$26.01
i)	Gross Premium (e+f+g+h)	$578.92
j)	Medical Loss Ratio (e/(i-c-h))	82.5%

12) Single Risk Pool

IUHP has not previously operated in the Individual market and thus does not have any claims experience to develop its own Single Risk Pool. This is a new filing based on manual rate projections. Please see the Credibility Manual Rate Development section for details regarding the rate development process.

13) Index Rate

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the Index Rate for the Experience Period has been left blank.

The Index Rate of $734.69 for the 2015 Projection Period represents the overall projected allowed costs PMPM for providing Essential Health Benefits for the Single Risk Pool. Since this is a new product, the index rate was developed based on a manual rate as described above in the Credibility Manual Rate Development section. The Index Rate will remain unchanged until a renewal filing effective January 1, 2016.

14) Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic characteristics of the Single Risk Pool. In other words, the Market Adjusted Index Rate is not calibrated.

The development of the Federal reinsurance program and risk adjustments was described above in the Risk Adjustment and Reinsurance section. The development of the Exchange user fee adjustment was described above in the Non-Benefit Expenses and Profit & Risk section.

Index Rate	$734.69
Reinsurance Reimbursements (7.0% of Allowed Claims – Index Rate)	($51.43)
Reinsurance Premiums	$ 3.67
Risk Adjustment	$ 0.00
Exchange user fee (3.15% of average premium for Single Risk Pool)	$ 18.24
Market Adjusted Index Rate	$705.17

15) Plan Adjusted Index Rates

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the Part I Unified Rate Review Template in 2015. These Plan Adjusted Index Rates have been adjusted to remove the portion of the allowed cost that is expected to be recouped through the tobacco surcharge. The average tobacco surcharge for the Single Risk Pool is approximately 1.4%.

The Plan Adjusted Index Rates reflect the average demographic characteristics of the Single Risk Pool. In other words, the Plan Adjusted Index Rates are not calibrated.

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

- Actuarial value and cost sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)
- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

Only the actuarial value and cost sharing & distribution and administrative costs adjustments were applicable to IUHP.

Actuarial Value and Cost Sharing Adjustment

This adjustment includes three components:

- Removal of tobacco surcharge - the average tobacco surcharge factor was applied to the average allowed costs for the Single Risk Pool
- Benefit richness utilization adjustments - The reference plan underlying our pricing was a Silver plan. Benefit richness utilization adjustments were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge). These adjustments were based on the values published in the Federal Register payment notice, normalized to the Silver plan level. The adjustments for each metallic tier are as follows:
    - Bronze = 1.00 / 1.03 = 0.9709
    - Silver = 1.00 / 1.00 = 1.0000
    - Gold = 1.08 / 1.03 = 1.0485
- Cost Sharing - The pricing model that developed the AV pricing values shown in Worksheet 2 of the URRT was used to calculate the cost sharing percentage for each plan. These cost sharing percentages were applied to the average allowed costs for the Single Risk Pool (after removing the impact of the tobacco surcharge and applying the benefit richness utilization adjustments). The estimated Cost Sharing Reduction (CSR) subsidies were calculated using the new advance payment methodology which was finalized in the 2015 HHS Notice of Benefit and Payment Parameters final rule (2015 Final Payment Notice).

Adjustment for Distribution and Administrative Costs

Fixed and variable costs as described in the Non-Benefit Expenses and Profit & Risk section were included in this adjustment as follows:

- Fixed costs: Risk adjustment user and PCORI fees
- Variable costs (% of premium): Administrative expenses, sales & marketing expenses, profit & risk margin, and premium taxes. The percentages applied did not vary by plan.

Appendix D shows the development of the Plan Adjusted Index Rates.

16) Calibration

The Plan Adjusted Index Rates (which are based on the Single Risk Pool) were calibrated to apply the allowable rating factors in order to calculate Consumer Adjusted Premium Rates. The calibration by age and geography is described below.

Age Curve Calibration

The methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology and conforms with the rating rules specified in 45 CFR 147.102.

The expected membership distribution by age band was based upon the Indiana Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. A uniform distribution within each age band was also assumed. A weighted average age factor of 1.685 for the Single Risk Pool was also determined by applying the membership distribution to the Federal age curve. This represents a rounded weighted average age of 49. Appendix C shows the development of the weighted average age factor.

The Plan Index Rates were calibrated by dividing by 1.706 which represents the standard age factor of the rounded weighted average age of 49. This calibration factor does not vary by plan.

Geographic Factor Calibration

A geographic factor calibration was not required since the weighted average of the geographic factors equals 1.0. The Geographic (rating area) factors were developed based upon the network characteristics for unit cost and utilization management in each of the established rating areas. Based upon the expected distribution of enrolment by area, the area factors reflect the Single Risk Pool results consistent with the URRT.

Appendix D shows how the calibration adjustments were applied to the Plan Adjusted Index Rates.

17) Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate

is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography if necessary, and applying the rating factors specified by 45 CFR Part 147, §147.102. The following adjustments are allowable under this rule:

- Whether the plan coverage covers an individual or family (issuers must cover any eligible individual and/or eligible family that requests coverage per the guaranteed issue requirement of the ACA); this is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor
- Rating area
- Age – reflecting the applicable age curve
- Tobacco status

The rating factors (shown in Appendix C) are applied at an individual level and added together to calculate the family rate, with the exception that no more than 3 covered children under the age of 21 are charged a rate. Adjustment for family size is in accordance with Federal rules. The examples in Appendix E show how the rating factors are applied to the calibrated Plan Adjusted Index Rate.

18) AV Metal Values

The Federal AV calculator was used without any modifications to generate the Metal Values included in Worksheet 2 of the URRT. Please refer to Appendix F for screen shots showing the AV calculations for each plan.

19) AV Pricing Values

The Silver Value plan was selected as the fixed reference plan and serves as the basis for the AV Pricing Values. Please refer to Appendix C for the AV Pricing Values for each plan which are also included in Worksheet 2, Section I of the URRT. The AV Pricing Value for each plan reflects the relative impact of the plan's cost-sharing amounts, expected impact on enrollee utilization due to benefit richness (excluding impact of morbidity), expected additional cost of non-EHB, and administrative expenses (excluding health insurance exchange user fees).

This is a new filing based on manual rate projections. IUHP did not have any base period experience, thus the PwC Rating Model as described above in the Credibility Manual Rate Development section was used to develop the benefit relativities for the AV Pricing Values.

20) Membership Projections

Membership projections were based on market penetration assumptions provided by IUHP. These assumptions reflected the uninsured and individual market populations by county, income level, and other characteristics such as the presence of IUHP facilities and delivery system within a given county.

The expected membership distribution by age band and metallic tier was based upon the Indiana

Exchange enrollment as of April 19, 2014 reported by the Department of Health and Human Services on May 1, 2014. For the Silver plans, the portion of the projected enrollment that will be eligible for CSR subsidies at each subsidy level was based on the income level detail in the market penetration analysis provided by IUHP.

Summaries of the projected membership by age, metallic tier, and CSR subsidy level are shown in Appendix B.

21) Terminated Products

Not applicable. IUHP does not currently have Individual plans in the State of Indiana.

22) Plan Type

All plans listed types in Worksheet 2, Section I of the URRT correctly describe IUHP's plans as "HMO".

23) Warning Alerts

Two warnings were generated in the URRT, both of which were due to adjustments to the allowed costs between Worksheet 1 and Worksheet 2. The first adjustment was the removal of the impact of the tobacco surcharge of 1.4% as required in the reporting of the Plan Adjusted Index Rates and related items in Worksheet 2. This resulted in a decrease in allowed claims of $xxxxx PMPM between Worksheets 1 and 2. The second adjustment was the application of the induced utilization factors in the development of the Plan Adjusted Index Rate for each plan. When aggregated, the impact of induced utilization was a reduction of xxxx% or $ yyyyy PMPM.

24) Company Financial Position

Please see Appendix G for information regarding the capital and surplus position of IUHP.

25) Reliance

In the preparation of this filing, I have relied upon data provided by Eric Neuville (Vice President Product Development and Innovation), Connie Brown (CFO and COO), and IUHP management. I did not audit this data but did review it for reasonableness. This information includes but is not limited to the following items:

- Administrative expense projections
- Provider reimbursement levels (including capitation arrangements)
- Projected enrollment
- Projected pharmacy discounts, unit costs and rebates
- Financial statement information

26) Actuarial Certification

I, Robert Macagnano, FSA, MAAA, am affiliated with PricewaterhouseCoopers LLP (PwC). I am a Member of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinion contained herein. This filing is prepared on behalf of Indiana University Health Plans, Inc. (the "Company").

I certify that this filing has been prepared in accordance with the following Actuarial Standards of Practice (ASOP) including:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications

I certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

I certify that the Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

On/Off Exchange Attestation

I certify that a single set of premium rates was submitted with this filing which is applicable for all plans offered both on and off the Exchange, and that this assures the same premium rate will be charged without regard to whether the plan is offered through the Exchange or whether the plan is offered directly from the Company or through an agent.

QHP Off Exchange Premium Tax Credit (PTC) Attestation

To notify consumers that coverage purchased outside of the Exchange is not eligible for premium tax credit assistance, the Company will include the following language in their marketing materials:

"DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payments Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Indiana Marketplace. Please be advised that this Policy does not qualify for these affordability programs because it was not issued through the Indiana Marketplace."

This disclaimer is located on page 1 of the Company's policy form.

The Part I Unified Rate Review Template does not demonstrate the process used by the Company to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Respectfully submitted,



Robert Macagnano, FSA, MAAA
Director
(973) 236-4082
Robert.Macagnano@us.pwc.com

Appendix A
Indiana University Health Plans, Inc.
Plan Design Summaries

Plan Name	Deductible	OOP Max	Coinsurance	PCP Visit	Specialist Visit	ER Visit	Inpatient Stay	Rx - Retail	Rx - Mail Order
IU Health Plans Gold Value	$750/$1,500	$6,000/$12,000	20% after deductible	$20 copay	$50 copay before deductible and 20% after deductible	$200 copay then deductible and 20% coinsurance	$500 copay then deductible and 20% coinsurance	$8/$20/20%/30%/30% (coinsurance applies after deductible)	$24/$60/20%/30%/30% (coinsurance applies after deductible)
IU Health Plans Silver HSA	$2,750/$5,500	$3,600/$7,200	10% after deductible	10% after deductible	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% after deductible	$15/$45/25%/35%/35% after deductible
IU Health Plans Silver Value	$2,500/$5,000	$6,350/$12,700	10% after deductible	$40 copay	10% after deductible	$250 copay then deductible and 10% coinsurance	$750 copay then deductible and 10% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Silver Enhanced	$2,000/$4,000	$5,750/$11,500	20% after deductible	$30 copay	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$5/$15/25%/35%/35% (coinsurance applies after deductible)	$15/$45/25%/35%/35% (coinsurance applies after deductible)
IU Health Plans Bronze HSA	$4,500/$9,000	$6,350/$12,700	20% after deductible	20% after deductible	20% after deductible	$250 copay then deductible and 20% coinsurance	$750 copay then deductible and 20% coinsurance	$10/$25/30%/40%/40% after deductible	$30/$75/30%/40%/40% after deductible
IU Health Plans Bronze Value	$6,000/$12,000	$6,350/$12,700	25% after deductible	$40 copay	25% after deductible	$350 copay then deductible and 25% coinsurance	$1,500 copay then deductible and 25% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)
IU Health Plans Bronze Enhanced	$5,000/$10,000	$6,350/$12,700	40% after deductible	$50 copay before deductible and then 40% after deductible	40% after deductible	$275 copay then deductible and 40% coinsurance	$750 copay then deductible and 40% coinsurance	$10/$25/30%/40%/40% (coinsurance applies after deductible)	$30/$75/30%/40%/40% (coinsurance applies after deductible)

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area

Member Distribution by Age	
Age Band	**Membership Distribution**
0-20	10.15%
21	1.09%
22	1.09%
23	1.09%
24	1.09%
25	1.09%
26	1.85%
27	1.85%
28	1.85%
29	1.85%
30	1.85%
31	1.85%
32	1.85%
33	1.85%
34	1.85%
35	1.68%
36	1.68%
37	1.68%
38	1.68%
39	1.68%
40	1.68%
41	1.68%
42	1.68%
43	1.68%
44	1.68%
45	2.12%
46	2.12%
47	2.12%
48	2.12%
49	2.12%
50	2.12%
51	2.12%
52	2.12%
53	2.12%
54	2.12%
55	2.98%
56	2.98%
57	2.98%
58	2.98%
59	2.98%
60	2.98%
61	2.98%
62	2.98%
63	2.98%
64	2.98%
65 and over	0.00%

Membership Distribution by Rating Area	
Rating Area	**Membership Distribution**
5	4.5%
7	30.9%
8	17.7%
10	9.0%
11	2.9%
13	29.9%
15	5.1%
Total	**100.0%**

Appendix B
Indiana University Health Plans, Inc.
Membership Distribution by Age and Rating Area
(continued)

		Silver					
Plan Name	**Gold**	**70**	**CSR 73**	**CSR 87**	**CSR 94**	**Bronze**	**Total**
IU Health Plans Gold Value	73						73
IU Health Plans Silver HSA		28	-	-	-		28
IU Health Plans Silver Value		168	152	284	69		673
IU Health Plans Silver Enhanced		84	76	142	35		337
IU Health Plans Bronze HSA						35	35
IU Health Plans Bronze Value						210	210
IU Health Plans Bronze Enhanced						105	105
Total	73	280	229	426	104	351	1,462

Appendix C
Indiana University Health Plans, Inc.
Rating Factors

Age-Based Tobacco Factors		
Age	**Smoker**	**Non-smoker**
0-20	1.000	1.000
21	1.050	1.000
22	1.050	1.000
23	1.050	1.000
24	1.050	1.000
25	1.050	1.000
26	1.050	1.000
27	1.050	1.000
28	1.050	1.000
29	1.050	1.000
30	1.050	1.000
31	1.070	1.000
32	1.090	1.000
33	1.110	1.000
34	1.130	1.000
35	1.150	1.000
36	1.170	1.000
37	1.190	1.000
38	1.210	1.000
39	1.230	1.000
40	1.250	1.000
41	1.270	1.000
42	1.290	1.000
43	1.310	1.000
44	1.330	1.000
45	1.350	1.000
46	1.370	1.000
47	1.390	1.000
48	1.410	1.000
49	1.430	1.000
50	1.450	1.000
51	1.470	1.000
52	1.490	1.000
53	1.490	1.000
54	1.473	1.000
55	1.410	1.000
56	1.348	1.000
57	1.290	1.000
58	1.234	1.000
59	1.208	1.000
60	1.158	1.000
61	1.118	1.000
62	1.094	1.000
63	1.065	1.000
64	1.048	1.000
65 and over	1.048	1.000

Federal Age Curve		
Age Band	**Membership Distribution**	**Age Factor**
0-20	10.15%	0.635
21	1.09%	1.000
22	1.09%	1.000
23	1.09%	1.000
24	1.09%	1.000
25	1.09%	1.004
26	1.85%	1.024
27	1.85%	1.048
28	1.85%	1.087
29	1.85%	1.119
30	1.85%	1.135
31	1.85%	1.159
32	1.85%	1.183
33	1.85%	1.198
34	1.85%	1.214
35	1.68%	1.222
36	1.68%	1.230
37	1.68%	1.238
38	1.68%	1.246
39	1.68%	1.262
40	1.68%	1.278
41	1.68%	1.302
42	1.68%	1.325
43	1.68%	1.357
44	1.68%	1.397
45	2.12%	1.444
46	2.12%	1.500
47	2.12%	1.563
48	2.12%	1.635
49	2.12%	1.706
50	2.12%	1.786
51	2.12%	1.865
52	2.12%	1.952
53	2.12%	2.040
54	2.12%	2.135
55	2.98%	2.230
56	2.98%	2.333
57	2.98%	2.437
58	2.98%	2.548
59	2.98%	2.603
60	2.98%	2.714
61	2.98%	2.810
62	2.98%	2.873
63	2.98%	2.952
64	2.98%	3.000
65 and over	0.00%	3.000
Weighted average age factor		1.685

Appendix C
Indiana University Health Plans, Inc.
Rating Factors
(continued)

Geographic Factors		
Rating Area	**Membership Distribution**	**Rating Area Factor**
5	4.5%	0.976
7	30.9%	0.976
8	17.7%	1.006
10	9.0%	1.060
11	2.9%	0.972
13	29.9%	1.010
15	5.1%	0.998
Total	**100.0%**	**1.000**

Plan Value Factors	
Plan Name	**Pricing Value**
IU Health Plans Gold Value	1.191
IU Health Plans Silver HAS	0.992
IU Health Plans Silver Value	1.000
IU Health Plans Silver Enhanced	1.009
IU Health Plans Bronze HAS	0.823
IU Health Plans Bronze Value	0.845
IU Health Plans Bronze Enhanced	0.855

Appendix D
Indiana University Health Plans, Inc.
Plan Adjusted Index Rate Development

Plan Name	Market adjusted index rate (a)	Actuarial value and cost sharing adjustment (b)	Adjustment for distribution and administrative costs (c)	Plan adjusted index rate (d) = (a) + (b) + (c)	Age calibration (e)	Geographic calibration (f)	Calibrated base rate (g) = (d) / [(e) x (f)]
IU Health Plans Gold Value	$ 705.17	$(139.80)	$128.75	$694.12	1.706	1.000	$406.87
IU Health Plans Silver HSA	$ 705.17	$(234.52)	$107.04	$577.69	1.706	1.000	$338.62
IU Health Plans Silver Value	$ 705.17	$(230.51)	$107.95	$582.61	1.706	1.000	$341.51
IU Health Plans Silver Enhanced	$ 705.17	$(226.33)	$108.90	$587.74	1.706	1.000	$344.51
IU Health Plans Bronze HSA	$ 705.17	$(314.62)	$88.73	$479.28	1.706	1.000	$280.94
IU Health Plans Bronze Value	$ 705.17	$(304.07)	$91.13	$492.22	1.706	1.000	$288.52
IU Health Plans Bronze Enhanced	$ 705.17	$(299.15)	$92.24	$498.26	1.706	1.000	$292.06

Appendix E
Indiana University Health Plans, Inc.
Rating Examples

Selected Plan:	IU Health Plans Silver Value
Rating Area:	Rating Area 11

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$341.51	0.972	2.230	1.410	$1,043.86
Spouse	40	Non-Smoker	$341.51	0.972	1.278	1.000	$424.28
Child 1	18	Non-Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 2	15	Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 3	13	Non-Smoker	$341.51	0.972	0.635	1.000	$210.81
Child 4	10	Non-Smoker	$341.51	0.972	0.635	1.000	$0.00
Total Premium							$2,100.57

Selected Plan:	IU Health Plans Gold Value
Rating Area:	Rating Area 7

				Base Premium Adjustments			
Member	Age	Tobacco Use	Base Premium	Area Factor	Age Factor	Tobacco Factor	Final Premium
Policyholder	55	Smoker	$406.87	0.976	2.230	1.410	$1,248.39
Spouse	40	Non-Smoker	$406.87	0.976	1.278	1.000	$507.41
Child 1	18	Non-Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 2	15	Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 3	13	Non-Smoker	$406.87	0.976	0.635	1.000	$252.12
Child 4	10	Non-Smoker	$406.87	0.976	0.635	1.000	$0.00
Total Premium							$2,512.14

Appendix F
Indiana University Health Plans, Inc.
Federal AV Calculator Results

IU Health Plans Gold Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☑		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.80	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.4%
Metal Tier:	Gold

IU Health Plans Silver HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.0%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver HSA - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.1%
Metal Tier:	Gold

IU Health Plans Silver HSA - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$400.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.1%
Metal Tier:	Platinum

IU Health Plans Silver Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver

IU Health Plans Silver Value - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.4%
Metal Tier:	Gold

IU Health Plans Silver Value - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

IU Health Plans Silver Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	75%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	65%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	65%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 73

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.3%
Metal Tier:	Silver

IU Health Plans Silver Enhanced - CSR 87

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.7%
Metal Tier:	Gold

IU Health Plans Silver Enhanced - CSR 94

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$150.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$650.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$9.00	☑	☑		
Preferred Brand Drugs	☑	☑	80%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	70%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum

IU Health Plans Bronze HSA

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.6%
Metal Tier:	Bronze

IU Health Plans Bronze Value

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	**Drug**	**Combined**	**Medical**	**Drug**	**Combined**
		$6,000.00			
		75.00%			
		$6,350.00			

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$350.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$1,500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze

IU Health Plans Bronze Enhanced

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,350.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑		$275.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$750.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☑		$50.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$16.00	☑	☑		
Preferred Brand Drugs	☑	☑	70%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	60%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.8%
Metal Tier:	Bronze

Appendix G
Indiana University Health Plans, Inc.
Capital, Surplus, and RBC Information

Annual Statement for the year 2013 of the Indiana University Health Plans, Inc.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)				
2. Stocks (Schedule D):				
2.1 Preferred stocks				
2.2 Common stocks				
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens				
3.2 Other than first liens				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ encumbrances)				
4.2 Properties held for the production of income (less $ encumbrances)				
4.3 Properties held for sale (less $ encumbrances)				
5. Cash ($ 6,645,144, Schedule E - Part 1), cash equivalents ($, Schedule E - Part 2), and short-term investments ($, Schedule DA)	6,645,144		6,645,144	8,006,798
6. Contract loans (including $ premium notes)				
7. Derivatives (Schedule DB)				
8. Other invested assets (Schedule BA)				
9. Receivables for securities				
10. Securities lending reinvested collateral assets (Schedule DL)				
11. Aggregate write-ins for invested assets				
12. Subtotals, cash and invested assets (Lines 1 to 11)	6,645,144		6,645,144	8,006,798
13. Title plants less $ charged off (for Title insurers only)				
14. Investment income due and accrued	1,068		1,068	2,137
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	231,209	66,791	164,418	201,607
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ earned but unbilled premiums)				
15.3 Accrued retrospective premiums				
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers				
16.2 Funds held by or deposited with reinsured companies				
16.3 Other amounts receivable under reinsurance contracts				
17. Amounts receivable relating to uninsured plans				
18.1 Current federal and foreign income tax recoverable and interest thereon				
18.2 Net deferred tax asset				
19. Guaranty funds receivable or on deposit				
20. Electronic data processing equipment and software				
21. Furniture and equipment, including health care delivery assets ($)				
22. Net adjustment in assets and liabilities due to foreign exchange rates				
23. Receivables from parent, subsidiaries and affiliates	332,038		332,038	714,499
24. Health care ($ 449,493) and other amounts receivable	1,838,476	915,716	922,760	616,348
25. Aggregate write-ins for other than invested assets	1,110,648	156,922	953,726	510,111
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	10,158,583	1,139,429	9,019,154	10,051,500
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28. Total (Lines 26 and 27)	10,158,583	1,139,429	9,019,154	10,051,500

DETAILS OF WRITE-IN LINES				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	NONE			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501. Estimated Medicare Settlement Receivable	953,726		953,726	510,111
2502. Prepaid General and Administrative Expenses	156,922	156,922		
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page				
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	1,110,648	156,922	953,726	510,111

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ 0 reinsurance ceded)				
2.	Accrued medical incentive pool and bonus amounts				
3.	Unpaid claims adjustment expenses				
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Services Act	29,399		29,399	105,075
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance	294,066		294,066	229,823
9.	General expenses due or accrued	818,192		818,192	1,431,649
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))				
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others				
13.	Remittances and items not allocated				
14.	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)				
15.	Amounts due to parent, subsidiaries and affiliates				12,550
16.	Derivatives				
17.	Payable for securities				
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified $ (0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans				
23.	Aggregate write-ins for other liabilities (including $ 0 current)	595,407		595,407	871,800
24.	Total liabilities (Lines 1 to 23)	1,737,064		1,737,064	2,650,897
25.	Aggregate write-ins for special surplus funds	XXX	XXX		
26.	Common capital stock	XXX	XXX	1,000	1,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	27,499,000	27,999,000
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	(20,217,910)	(20,599,397)
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX		
	32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	7,282,090	7,400,603
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	9,019,154	10,051,500

	DETAILS OF WRITE-IN LINES				
2301.	Estimated Medicare Settlement Liability	338,139		338,139	667,855
2302.	Other Amounts Payable	257,268		257,268	203,945
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	595,407		595,407	871,800
2501.		XXX	XXX		
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

NONE

NONE

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL - XR025

		Abbreviation	(1) Amount	(2) Result
(1)	**Total Adjusted Capital, Post-Tax**		7,282,090	
(2)	Company Action Level=200% of Authorized Control Level	CAL	4,146,860	
(3)	Regulatory Action Level=150% of Authorized Control Level	RAL	3,110,145	
(4)	Authorized Control Level=100% of Authorized Control Level	ACL	2,073,430	
(5)	Mandatory Control Level=70% of Authorized Control Level	MCL	1,451,401	
(6)	Level of Action, if Any		NONE	

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	7,282,090
Authorized Control Level Risk-Based Capital on Line 15 of the Five Year Historical Data Page	2,073,430

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8	98,250,957	
(8)	Underwriting Deductions	Page 4, Line 23	97,709,883	
(9)	Combined Ratio	Line (8)/Line(7)	99.400	
(10)	RBC Ratio	Line(1)/Line(4)	351.200	
(11)	Trend Test Result	If Line(10) is between 200% and 300% and Line (9) > 105%, then "Yes", otherwise "No"		No
(12)	Level of Action, if any, including Trend Test		NONE	