Evidence of Coverage
(herein called the "EOC")

Indiana University Health Employee Benefit Plans powered by Eyemed

Issued by:

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

The vision coverage described in this Evidence of Coverage ("EOC") is effective on the date shown on the Schedule of Benefits only if you are eligible for the coverage, become covered, and remain covered subject to the term, limitations and conditions of the Group Contract (referred to in this EOC as the "Contract"). You and any family members named on the IU Health Plans Identification Card(s), for whom the required Premium has been paid, are entitled to coverage under the Group Contract (referred to in this EOC as the "Contract") provided you meet the eligibility requirements stated in the Contract.

This EOC is evidence of your coverage under the contract issued to your Employer for your benefit.

Your coverage is subject to exclusions, limitations, conditions and other terms of the Contract. It is important that you carefully review this EOC, including any amendments, and the Schedule of Benefits, and become familiar with its terms, exclusions, limitations and conditions.

The Contract may be examined at the main office of your Employer.

READ YOUR EVIDENCE OF COVERAGE CAREFULLY.

If you have questions related to your vision coverage, you may contact us at [toll free number].

James Parker
President and CEO

Coverage under this EOC is limited to Vision Services ONLY for individuals age 19 and older.

Federal Notices

Statement of ERISA Rights

As a participant in the Employer's ERISA benefit plans, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to the following:

Receive Information About Your Plan And Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your Dependents if there is a loss of coverage under the plan as a result of a qualified life event change. You or your Dependents may have to pay for such coverage.

Receive a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under a plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ends, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the plan's claims review and appeal procedures. In addition, if you disagree with a decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your coverage, you should contact [your Employer][contact and telephone number]. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.]

Notices Required by State Law

Notice to Members

Questions regarding your coverage should be directed to:

Indiana University Health Plans
950 N Meridian St; Suite 200
Indianapolis, IN 46204

(844)230-6500

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 may be filed electronically at www.in.gov/idoi

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ARTICLE 1. DEFINITIONS

In this Evidence of Coverage, the terms “we”, “us” or “our” refer to Indiana University Health Plans, Inc. The term “you” refers to you, the Enrollee, who is eligible for and enrolled in coverage.

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

Child or Children – a child of the Subscriber or Subscriber's Spouse, age 19 to 26, including any of the following.

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

Child includes one 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 one hundred twenty (120) 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.

Contract – the Group Contract, the Evidence of Coverage, the Schedule of Benefits and any amendments or riders to any of these documents collectively constitute the Contract.

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.

Covered Services –Health Care Services performed, prescribed, directed or authorized by a Provider and for which the Contract provides Benefits. To be a Covered Service, the Health Care Service must be all of the following.

- Medically Necessary
- Within the scope of the license of the Provider.
- Rendered while coverage under the Contract is in force.
- Not experimental/investigative.
- Authorized in advance by us if Precertification is required under the Contract.
- Not excluded or limited by the Contract.

Dependent – a person who is either the Subscriber’s 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.

Domestic Partner – the Domestic Partner of the Subscriber who is a person of the same or opposite sex for whom all of the following are true.

- He or she is the sole Domestic Partner of the Subscriber ;
- Each person is at least 18 years of age or older and competent to enter into a contract;
- Both persons currently share a common legal residence;
- Neither person is married to anyone or related to the other by adoption or blood to a degree of closeness that would otherwise bar marriage;
- Both persons are in a relationship of mutual support, caring, and commitment and they intend to remain in such a relationship in the indefinite future;
- Both persons are jointly responsible for basic living expenses (basic living expenses are defined as the cost of basic food, shelter, and any other expenses of the common household. The partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- Neither party filed a Termination of Domestic Partnership.

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

Employer – the entity to which the Group Contract has been issued.

Enrollee – the Subscriber or any Dependent who meets all applicable eligibility requirements for coverage under the Group Contract, is enrolled as provided in the Group Contract, and for whom the required premium payment has been received by us. Enrollees are referred to as "you" and "your" in the EOC.

Evidence of Coverage or EOC – this document makes up the Enrollee's Evidence of Coverage. It provides the essential features and services of the coverage provided to Enrollees under the Group Contract.

Group Contract – the contract between Indiana University Health Plans, Inc. and Employer which provides Benefits for Covered Services for Subscribers and enrolled Dependents.

Health Care Services – vision services, whether or not covered under the Contract.

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

(1) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for your illness, injury or disease.

(2) Required for the direct care and treatment or management of your illness, injury or disease.

(3) If not provided, your condition would be adversely affected.

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

(5) Not primarily for the convenience of you, your family, the physician or another prescribing Provider.

(6) 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.

The definition of Medically Necessary under the 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.

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

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

Open Enrollment Period – the number of days each year during which eligible employees and their dependents may enroll for coverage under the Contract. See the "Eligibility and Enrollment" article of this EOC for more information.

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

Plan Year – the 12 month period during which the Contract is in effect.

Provider – a vision care provider licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

Schedule of Benefits – the part of the Contract that sets forth Cost Sharing, Out of Pocket Maximums, limitations and other information regarding your coverage under the Contract.

Service Area – the following counties: [insert list of counties].

Special Enrollment Periods – enrollment periods administered by us that occur outside of the Open Enrollment Period, typically due to a triggering event such as marriage, etc. See the Article 2 "Eligibility and Enrollment" for more information.

Spouse – the Subscriber's legal spouse or Domestic Partner.

Subscriber – an employee of the Employer who is eligible for and enrolled in coverage under the Contract.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT.

In this Article 2 you will find information on who is eligible for coverage under the Contract and when Dependents may be added to your coverage. Eligibility requirements are described in general terms below. For more details, please see your Human Resources Department or Benefits Department.

A. **You as the Subscriber.** 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) Be an employee, other than a seasonal employee, of Employer;

(2) Meet the Employer's waiting period, if any.

(3) Be employed to work a minimum [number of hours per week as required by the Employer and agreed to by us] [of 30 hours each week] [or be an eligible retiree according to the guidelines agreed upon by the Employer and us].

(4) Reside or work in the Service Area.

B. **Your Dependents.** To be eligible as a Dependent, the other person must either be your Spouse or your Child.

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

D. **Initial Enrollment.**

(1) Employer will offer an initial enrollment period to new Subscribers and their Dependents when a Subscriber is first eligible for coverage.

(2) Coverage will be effective after a waiting period determined by the Employer. The waiting period shall not exceed 90 days.

(3) If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during an Open Enrollment Period or during a Special Enrollment Period, as described below.

E. **Open Enrollment.** Each calendar year the Employer will provide you with a prior written notice of the Open Enrollment Period during which time eligible Subscribers and Dependents can apply for or change coverage.

F. **Special Enrollment Periods.** If you did not enroll yourself and/or your Dependents during the initial enrollment period you may qualify for a Special Enrollment Period.

(1) If you declined enrollment for yourself or your Dependents because of other health insurance coverage and that coverage ends due to a loss or eligibility, the COBRA coverage was exhausted or the employer contribution to the other coverage ended, you may enroll yourself or your Dependents for health care coverage as long as you request enrollment within 30 days after your other coverage ends.

(2) If you gain a new Dependent as a result of marriage, you may enroll yourself and your Dependents as long as you request enrollment within 30 days after the date of marriage.

(3) If you or your Dependent either loses coverage under Medicaid or CHIP as a result of loss of eligibility or becomes eligible for a premium subsidy through a

state premium assistance program, you may enroll yourself and your Dependents as long as you request enrollment within 60 days after the event.

(4) If you miss the 30- or 60-day deadlines noted above, you will have to wait until the next Open Enrollment period to enroll.

G. Adding New Dependents.

(1) Dependent Children. You may enroll your Children ages 19 to 26 for coverage under this Contract. Please contact us by visiting [website] or calling [toll free number] for information on how to add your Child as a new Dependent.

(2) Spouse or Loss 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 the Contract, provided you submit to us a form to add your new Dependent and we receive payment for additional applicable premium, if any, within 30 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:

(i) Termination of employer contributions.

(ii) Exhaustion of COBRA continuation of coverage.

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

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

(ii) 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 may not be added to your coverage until the next Open Enrollment Period.

H. Notification of Changes.

(1) Responsibility to Notify Us. You are required to notify us of any changes in your eligibility or the eligibility of your Dependents for Benefits under the Contract. 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, 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 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 Us. Failure to notify us of persons no longer eligible for coverage under the Contract will not obligate us to provide Benefits to those no longer eligible. Our acceptance of payments for persons no longer eligible for services will not obligate us to pay for such Benefits.

(3) Effective Date of Termination Due to Change in Eligibility. Regardless of whether we receive timely notice, an Enrollee's coverage will terminate on the day such Enrollee ceases to be eligible for coverage under the Contract. We have the right to bill you for the cost of any Health Care Services provided to an Enrollee during the period such Enrollee is not eligible under the Contract. If you think there are reasons coverage of the person experiencing the change should continue, you must notify us of the reasons for the continuation of the coverage no later than 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 your 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 the 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 may result in termination or rescission of coverage.

ARTICLE 3. YOUR FINANCIAL OBLIGATIONS

A. Premium.

(1) Your Employer must pay premium to us each month for coverage under the Contract. You may be required to contribute to the premium. Your premium may change if Dependents are enrolled or disenrolled in your coverage.

(2) Your Employer is entitled to a 31 day period beginning on the premium invoice due date ("Grace Period"), for the payment of any premium or other amounts due. During the Grace Period the Contract will remain in force unless your Employer gives us advanced written notice of its intent to terminate the Contract. We are not obligated to pay any claims incurred during the Grace Period, until the full amount due is received.

(3) If your Employer fails to pay the required premium within the applicable Grace Period, your Employer shall be considered to be in default in payment of premiums and the Contract may be terminated as provided in the Contract. We may also temporarily suspend claims payments, although ultimately claims payments due pursuant to the Contract shall be made by us.

B. Copayments. 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.

C. Payments for Non-Covered Services. You are responsible for payment of all expenses for Non-Covered Services.

D. Participating Providers and Non-Participating Providers.

(1) Unless specifically stated in the Schedule of Benefits, an Enrollee must receive Covered Services from a Participating Provider and Health Care Services received from Non-Participating Providers are Non-Covered Services.

(2) The Enrollee 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].

ARTICLE 4. COVERED SERVICES AND EXCLUSIONS

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides Benefits for the following Medically Necessary vision services for an Enrollee beginning on the first day of the month after the Enrollee obtains the age of 19. Payment for Covered Services is limited by any applicable Cost Sharing or Benefit limitations set forth in this Contract including the Schedule of Benefits.

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.

A. Covered Services.

(1) Complete Eye Examination. See the Schedule of Benefits for additional information on this Covered Service, including Benefit limitations.

(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 single vision, bifocal, trifocal or lenticular lenses. See the Schedule of Benefits for additional information on this Covered Service, including Benefit limitations.

(3) Frames. This Contract offers a selection of frames available at Provider locations. See the Schedule of Benefits for additional information on this Covered Service, including Benefit limitations.

(4) Contact Lenses. Coverage includes contact lens fit and follow-up, conventional and disposable. See the Schedule of Benefits for additional information on this Covered Service, including Benefit limitations.

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

(1) Health care services that are not specifically identified as Covered Services in this Article 4 or in the Schedule of Benefits.

(2) Services that we determine are not Medically Necessary or are experimental or investigational.

(3) Services that exceed the frequency limitations set forth in the Schedule of Benefits.

(4) Services, drugs or medications that not part of a vision examination.

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

(6) 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.

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

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

(9) 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.

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

(11) Charges for consulting with Enrollees by telephone, facsimile, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Enrollee except as otherwise described in the Contract.

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

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

(14) 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.

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

(16) 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.

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

(18) Missed or canceled appointments.

(19) Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if an Enrollee had applied for Parts A, B and/or D, except, as specified elsewhere in the Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Enrollee has not

enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.

(20) Services incurred prior to the Effective Date.

(21) Services incurred after the termination date of this coverage.

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

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

(24) Examinations relating to research screenings.

(25) Stand-by charges of a Provider.

(26) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.

(27) Medical and/or surgical treatment of the eye, eyes or supporting structures.

(28) Any eye or vision examination, or any corrective eyewear required by your Employer as a condition of employment; safety eyewear.

(29) Plano (non-prescription) lenses and/or contact lenses.

(30) Non-prescription sunglasses.

(31) Two pair of glasses in lieu of bifocals.

(32) Services rendered after the date an Enrollee ceases to be under the Contract, except when vision materials ordered before coverage ended are delivered, and the services rendered to the Enrollee are within 31 days from the date of such order.

(33) Notwithstanding Article 7, Coordination of Benefits, services or materials provided by any other group benefit plan providing vision care.

(34) Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when the vision materials would next become available.

ARTICLE 5. GRIEVANCE AND APPEAL PROCEDURES.

This Article 5 sets forth the procedures for Grievances and Appeals.

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.

Indiana University Health Plans
950 N Meridian St; Suite 200
Indianapolis, IN 46204

(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 5. 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 5.

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 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 20 business days after your Grievance was filed.

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

(5) Notice of Decision. Within 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 by contacting us at the address and phone number provided below.

Indiana University Health Plans
950 N Meridian St; Suite 200
Indianapolis, IN 46204
(800

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

(e) We will provide continued coverage pending the outcome of an appeal.

(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 72 hours advance notice of the date and time of the meeting.

(c) You or Your Designated Representative may:

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

(ii) 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.

(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:

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

(ii) 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

(iii) 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 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 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) 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.

(d) 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.

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.

(2) If your Appeal did not involve one of the above adverse decisions, you are not entitled to an External Review.

(3) 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 the Contract.

(4) 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.

(5) 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 72 hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within 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 24 hours if the review involves an Urgent Care Claim that qualified for our Expedited Internal Appeals process or within 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.

H. Important Contact Information and Notice to Enrollees.

(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.

(3) The review procedures described in this Article 5 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 6. 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 6.

B. Who Receives Payment Under The 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, 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.

(1) Time to File Claims. Written notice of a claim must be given to us, by you or the Provider, within 30 days of the date the Covered Services began. Failure to furnish the claim within 30 days will not invalidate or reduce any claim if submission within 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 15 days of notice of any claim. If you do not receive the forms within 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 the Contract must be furnished to us within 90 days after the loss. Failure to furnish the claim within 90 days will not invalidate or reduce any claim if submission within 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 the Contract unless you were legally incapacitated.

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

Indiana University Health Plans
950 N Meridian St; Suite 200
Indianapolis, IN 46204

(5) Amount of Payment. Payment for Health Care Services 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 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 30 days after the date we receive the claim.

(b) If the claim is filed on paper, within 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 7. COORDINATION OF BENEFITS

This Article 7 applies only if you also have other health benefits coverage with another Plan. The Definitions contained in this Article apply throughout this Article 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 the 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 Enrollees 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 Enrollee.

(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:

(i) The parents are married;

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

(iii) 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:

(i) The Plan of the Custodial Parent.

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

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

(iv) 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 if 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 7.

(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 Enrollee 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 Enrollee; 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 Enrollee'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 an Enrollee 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 8. TERMINATION OF COVERAGE

A. Termination. We may terminate coverage of an Enrollee for the following reasons.

(1) The Contract between the Employer and us terminates.

(2) You or your Dependent are no longer eligible for coverage under the terms of the Contract.

(3) You request coverage to be terminated.

(4) You commit an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact including but not limited to misuse of your Identification Card.

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

B. Effective Date of Termination. Termination of the Group 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) In the event of termination of the Group Contract or coverage for an Enrollee, 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.

(2) 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.

(3) 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.

C. Notice of Termination.

(1) We shall provide you with written notice of our intent to terminate or not renew the Contract at least 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 Enrollees and is sufficient if mailed to the Subscriber's address as it appears in our records.

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

D. Continuation of Coverage under State Law. If the Group Contract terminates due to our receivership, coverage will continue for the duration of the contract period for which premiums have been paid.

E. Continuation of Coverage Under Federal Law.

(1) Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If coverage under the Contract ceases for you or your Dependents under certain circumstances, you and your Dependents may be able to continue coverage under the Contract under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employers with 20 or more employees are usually required to offer COBRA coverage and to notify their employees of the availability of such coverage.

Please contact Employer to determine if the Contract is subject to COBRA continuation coverage.

(a) COBRA continuation coverage is a continuation of coverage under the Contract when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your or your Dependents could become qualified beneficiaries if coverage under the Contract is lost because of the qualifying event. Under the Contract, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

(b) If you are an employee and the Contract is subject to COBRA, You will become a qualified beneficiary if you lose your coverage under the Contract because either one of the following qualifying events happens:

(i) Your hours of employment are reduced, or

(ii) Your employment ends for any reason other than your gross misconduct.

(c) If you are the Spouse of an employee and the Contract is subject to COBRA, you will become a qualified beneficiary if you lose your coverage under the Contract because any of the following qualifying events happens:

(i) Your Spouse dies;

(ii) Your Spouse's hours of employment are reduced;

(iii) Your Spouse's employment ends for any reason other than his or her gross misconduct;

(iv) Your Spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(v) You become divorced or legally separated from your Spouse.

(d) If the Contract is subject to COBRA, your Children will become qualified beneficiaries if they lose coverage under the Contract because any of the following qualifying events happens:

(i) The parent-employee dies;

(ii) The parent-employee's hours of employment are reduced;

(iii) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(iv) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(v) The parents become divorced or legally separated; or

(vi) The Child stops being eligible for coverage under the Contract.

(e) COBRA coverage will be offered to each qualified beneficiary who timely elects and pays required COBRA premiums to us, provided that Employer has timely notified the qualified beneficiary of his eligibility to elect COBRA and has timely notified us of the qualifying event. Employer is responsible for the timely mailing of applicable COBRA notices to each individual covered by the Contract. We are not responsible for mailing or distributing an initial notice or a notice upon the occurrence of any qualifying event.

(f) When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), Employer must notify the plan administrator or COBRA administrator (if one has been appointed for COBRA administration) of the qualifying event.

(g) For the other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent Child losing eligibility for coverage as a Dependent Child), you must notify Employer within 60 days after the qualifying event occurs. In addition, if applicable, you must provide a certified copy of the court order granting the divorce or legal separation.

(h) Once Employer receives notice that a qualifying event has occurred, it must notify us and ensure each qualified beneficiary receives a COBRA notice so that COBRA continuation coverage will be offered to each of the qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A Subscriber may elect COBRA continuation coverage on behalf of his/her Spouse, and may elect COBRA continuation on behalf of their Children.

(i) COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Subscriber, the Subscriber becoming entitled to Medicare (Part A, Part B, or both), your divorce or legal separation, or a Child losing eligibility, COBRA continuation coverage lasts up to a total of 36 months. When the qualifying event is the end of employment or reduction of hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways

in which this 18-month period of COBRA continuation coverage can be extended.

(i) Disability Extension of 18-month Period of Continuation Coverage. If you or your enrolled Dependent is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, you and your enrolled Dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to start at some time before the 60th day of COBRA continuation coverage and last at least until the end of the 18-month period of continuation coverage. You must make sure that the Employer is notified of the Social Security Administration determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

(ii) Second Qualifying Event Extension of 18-month Period of Continuation Coverage. If your enrolled Dependents experience another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Employer. This extension may be available to the Spouse and any Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Child stops being eligible under the Contract, but only if the event would have caused the Spouse or Child to lose coverage under the Contract had the first qualifying event not occurred. In all of these cases, you must make sure that the Employer is notified of the second qualifying event within 60 days of the second qualifying event.

(j) Questions concerning Your COBRA continuation coverage should be addressed to your Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health benefits, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

(k) In order to protect your rights, you should keep your Employer informed of any changes in the addresses of Dependents. You should also keep a copy, for your records, of any notices you send to your Employer.

(2) Employees on Military Leave. Employees going to or returning from military service will have continuation rights mandated by the Uniformed Service

Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Immediate overage is available with no pre-existing condition exclusion applied upon return from service. These rights apply only to Enrollees who are covered under this Contract before leaving for military service.

(3) Family and Medical Leave Act of 1993. A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 will still be eligible for coverage during his/her leave. We will not consider the Subscriber or his/her Dependents to be ineligible because the Subscriber was not at work. If the Subscriber ends his/her coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may re-enrolled in coverage when the Subscriber returns to work. To be re-enroll, the Employer may be required to give us evidence that the Family and Medical Leave Act applied to the Subscriber.

F. Rescission. If within two (2) years after the Effective Date of the Contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or an Enrollee did not disclose on your application, we may rescind the Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or an Enrollee 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 an Enrollee may result in termination or rescission of coverage. You are responsible to pay us for the cost of previously received services less any Copayments paid for such services.

The 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 the 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 the Contract.

ARTICLE 9. GENERAL PROVISIONS

A. No Assignment. The benefits provided under the Contract are for your and your enrolled Dependents' personal benefit. You may not assign any of your rights to coverage. 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.

B. Notice. Any notice that we give to you under the 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 3 calendar days after its deposit in the United States Mail with first class postage prepaid unless otherwise stated in the 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

C. **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 Enrollee is that of Provider and patient. The Provider is *solely* responsible for the services provided to any Enrollee.

D. **Your Medical Records.** As a condition precedent to the approval of claims hereunder, each Enrollee 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 the Contract. In every case we will hold such information and records as confidential in accordance with state and federal confidentiality requirements.

E. **Who May Change The Contract.** The 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 the Contract not later than 60 days prior to the date on which such material modification will become effective.

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

G. **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 orientation; 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.

H. **Limitation of Action.** Requests for reimbursement are subject to the provisions of the 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 the Contract and within three (3) years from the date the Health Care Services were received.

I. **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 Enrollee or Provider) or any other appropriate party.

J. **Subrogation and Reimbursement.** To the extent permitted by law, (1) we have the right to recover amounts we pay for Benefits from any third party that is responsible for compensating you for an injury; and (2) if you obtain a recovery from or on behalf of a third party and we have not been repaid for amounts we paid for Benefits we have a right to be repaid by you from such recovery. You agree to notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved. You agree to cooperate with us in the investigation, settlement and protection of our rights and agree not to do anything to prejudice our rights.

K. **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 the 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.

L. **Typographical or Administrative Error.** Typographical or administrative errors shall not deprive an Enrollee 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.

M. **Conformity with Statutes.** The intent of the Contract is to conform to applicable laws and regulations in effect on the date the Contract became effective. The laws and regulations of the jurisdiction in which the 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.

N. **Governing Law.** The Contract will be subject to the laws of the state of Indiana.

O. **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.