IU Prescription Plan

Summary of Plan Provisions

Full-time Academic and Staff Employees

JAN 2017

Prescription Drug Coverage Administered by
Express Scripts

Foreward

This Prescription Benefit document describes how to get prescription medications, what medications are covered and not covered, and what portion of the prescription costs you will be required to pay.

Express Scripts, the Pharmacy Benefit Manager (PBM), manages your prescription drug benefit under contract with Indiana University (the Plan). Express Scripts maintains the Preferred Drug list (also known as a Formulary), manages a network of retail pharmacies, and operates the Home Delivery and Specialty Drug pharmacies. Express Scripts, in consultation with the Plan, also provides services to promote the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions, and other safety measures.

Employees and dependents covered by Indiana University's prescription drug benefit can use either retail pharmacies or the Express Scripts Home Delivery service. The benefit covers most prescription drugs, plus insulin and some over-the-counter (OTC) diabetic supplies, and some OTC items considered preventative under the Health Care Reform Act. Certain medications are subject to limitations and may require prior authorization for continued use.

Retail Pharmacies

Retail pharmacy service is most convenient for short-term prescription needs. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in the Express Scripts network. At retail, you can get up to a 30-day supply.

The Express Scripts pharmacy network includes most retail chain pharmacies and supermarket pharmacy chains. Some independent pharmacies are also included. Walgreens is not part of the network for Indiana University plans. To locate network pharmacies, visit **www.express-scripts.com** or call 800-988-1794.

Home Delivery (Mail Order)

Members that need medications on an ongoing basis can ask their doctor to prescribe up to a 90-day supply, plus refills if appropriate. Examples are ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma. Just a single copayment is required for each 90-day prescription.

- Medications are shipped standard delivery at no additional cost.
- First-time orders are usually delivered within 8 to 11 days after the order is received. Refills usually arrive in less time – refills ordered online are usually delivered within 3 to 5 days and refill orders mailed in are usually delivered within 6 to 9 days.
- Medication packages will include instructions for ordering refills, if applicable, and may also include information about the purpose of the medication, appropriate dosage guidelines, and other important details.
- You can track your prescriptions and order refills at **www.express-scripts.com** or by calling 800-988-1794.
- Registered pharmacists are available around the clock for consultation.

Specialty Pharmacy

Express Scripts has a separate arrangement for specialty medications through Accredo. Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis.

For more information on specialty medications, visit **www.express-scripts.com** or call 800-988-1794

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How to Obtain Prescription Drug Benefits

How you obtain your benefits depends on whether you go to a network or non-network pharmacy.

Network Retail Pharmacy

The retail pharmacy network includes the following chains: CVS, Wal-Mart, Meijer, Target, Kroger, Marsh, and more.

For the names of participating pharmacies, visit **www.express-scripts.com** or call 800-988-1794.

Present your written prescription from your physician and your ID card to the pharmacist at a network retail pharmacy. Alternatively, some physicians send prescriptions to pharmacies electronically and you will just need to present your ID card. The Pharmacy will submit your claim for you. You will be charged at the point of purchase for applicable deductible and/or copayment/coinsurance amounts.

If you do not present your ID card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to Express Scripts using a direct claim reimbursement form.

Express Scripts Home Delivery

Through this service, you may receive up to a 90-day supply of many maintenance medications.

Complete the order form and the Health, Allergy, & Medication Questionnaire the first time you order through this service. You may mail written prescriptions from your physician, or have your physician fax or send the prescription electronically to Express Scripts. A doctor must submit it directly to Express Scripts.

You will need to submit the applicable deductible, co-insurance and/or copayment amounts to the Express Scripts Pharmacy when you request a prescription or refill.

Medications are shipped standard delivery at no additional cost. You can track your prescriptions and order refills at **www.express-scripts.com** or by calling 800-988-1794. Registered pharmacists are available around the clock for consultation.

Specialty Drugs

Specialty medications are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis.

Accredo offers therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs.

For more information or to order your specialty medications, please call Customer Service at 800-988-1794.

Out-of-Network Retail Pharmacy

If you visit a non-network retail pharmacy, you are responsible for payment of the entire amount charged by the non-network retail pharmacy and will then need to submit a prescription drug claim to Express Scripts for reimbursement consideration. These forms are available from Express Scripts by calling the Customer Service number on the back of your ID card or by visiting **www.express-scripts.com**.

You must complete the form, attach an itemized receipt to the claim form, and submit to Express Scripts. The itemized receipt must show:

- name and address of the non-network retail pharmacy
- patient's name
- prescription number
- date the prescription was filled
- NDC number (drug number)
- name of the drug and strength
- cost of the prescription
- quantity and days' supply of each covered drug or refill dispensed
- Doctor name or ID number
- DAW (dispense as written) code
- You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by Express Scripts' normal or average contracted rate with network pharmacies on or near the date of service.

Covered Services

Prior Authorization

Prior Authorization may be required for certain prescription drugs (or the prescribed quantity of a particular drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage.

At the time you fill a prescription, the pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. Express Scripts uses criteria developed by their Pharmacy and Therapeutics Committee and they are reviewed and adopted by the Plan. Express Scripts may contact your provider if additional information is required to determine whether Prior Authorization should be granted. Express Scripts communicates the results of the decision to both you and your provider.

If Prior Authorization is denied, written notification is sent to both you and your providers. You have the right to appeal through the appeals process. The written notification of denial you receive provides instructions for filing an appeal.

To ask if a drug requires Prior Authorization, please contact Express Scripts at the Customer Service telephone number on the back of your ID card.

You, your provider, or pharmacist, may check with Express Scripts to verify covered prescription drugs, any quantity and/or age limits, prior authorization, or other requirements.

Formulary or Preferred Drug List

A formulary is a list of commonly prescribed medications from which your physician may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other non-formulary medications, can help contain the increasing cost of prescription drug coverage while maintaining the high quality of care.

You may request a copy of the preferred drug list or formulary by calling Express Scripts at the Customer Service telephone number on the back of your ID card or view the list online at **www.express-scripts.com**.

The preferred drug list is subject to periodic review and amendment and the inclusion of a drug or related item on the preferred drug list is not a guarantee of coverage.

Therapeutic Interchange is a formulary management program approved by the Plan and managed by Express Scripts. This is a voluntary program designed to inform members and physicians about possible alternatives to certain prescribed drugs. Express Scripts may contact you or your prescribing physician to make you aware of preferred alternatives. Therapeutic interchange may also be initiated at the time the prescription is dispensed.

For questions or issues involving therapeutic drug substitutes, contact Express Scripts by calling the

Customer Service telephone number on the back of your ID card. The therapeutic interchange drug list is subject to periodic review and amendment. No change in the medication prescribed for you will be made without you, or your physicians' approval.

Step Therapy

The Plan participates in programs to encourage the prescribing of generics and lower cost alternative preferred brand drugs. These programs may produce savings to you.

Step therapy protocol means that a member may need to use one type of medication before another. If physician approved, the more cost-effective medication will be dispensed. If the physician does not approve and prefers a non-preferred drug, prior authorization is needed.

Specialty Pharmacy Network

"Specialty Drugs" are (A) used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis; (B) Are typically injected, infused or require close monitoring by a physician or clinically trained individual; or (C) Have limited availability, special dispensing and delivery requirements, and/or require additional patient support.

Accredo, Express Scripts' Specialty Pharmacy, provides personalized counseling, expedited delivery, supplies, and safety checks.

If you or a dependent uses specialty medications, you must order through Accredo.

Accredo offers:

- Free expedited scheduled delivery to the location you choose (your home, doctor's office, outpatient clinic), and free supplies to administer your medication (e.g., needles, syringes).
- Individualized support from trained nurses and patient care representatives.
- 24/7 access to registered pharmacists for questions.

Accredo, the specialty pharmacy, must be used to fill specialty drug prescription orders, subject to a 30-day supply the applicable coinsurance or copayment shown in the Schedule of Benefits.

To order specialty medications from Accredo, please call the Customer Service telephone number on the back of your ID card or have your doctor call 800-987-4904 between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.

Covered Prescription Drug Benefits

Prescription drugs, unless otherwise stated below, must be medically necessary and not experimental/investigative, in order to be Covered Services. For certain prescription drugs, the prescribing physician may be asked to provide additional information before Express Scripts and/or the

Plan can determine medical necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific prescription drugs.

Covered Services will be limited based on medical necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

Covered Prescription drug benefits include:

- Prescription legend drugs
- Certain OTC medications as indicated under the Affordable Care Act*
- Injectible insulin
- Needles and syringes used for administration of insulin
- Non-insulin needles and syringes
- Contraceptive drugs: oral, transdermal, intravaginal, and injectible
- Contraceptive devices
- Prescription vitamins including prescription fluoride supplements as well as those covered under the Affordable Care Act*
- Influenza immunizations
- Immunizations covered under the Affordable Care Act*
- Certain supplies and equipment are covered such as diabetic test strips, lancets, swabs, glucose monitors, insulin pumps and inhaler spacers. If certain supplies, equipment or appliances are not available through the prescription benefit, they may be available through the medical benefit.
- Injectables unless otherwise noted as benefit exclusions.
- Prescription medical foods such as nutritional supplements, infant formulas, supplements to treat inherited metabolic diseases (including PKU)
- Prescription and some OTC smoking cessation drugs**
- Select pharmacogenomic tests used to guide the selection and dosing of medications

Non-Covered Prescription Drug Benefits

Non-Covered Prescription drug benefits include:

- Over the counter drugs except insulin and those covered under the Affordable Care Act*
- Over the counter vitamins except those covered under the Affordable Care Act*
- Estriol compounds
- Medications used for cosmetic purposes only such as hair growth stimulants
- Allergy sera
- Blood and blood plasma products except for hemophilia factors
- Experimental/ Investigative Drugs
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Drug treatment related to infertility.
- Over the counter homeopathic or herbal medicines

* Certain prescription and OTC medications are considered preventative by the Affordable Care Act and are covered by the benefit. A prescription is required to obtain these preventative medications through your prescription benefit.

** Tobacco cessation prescriptions and nicotine replacement products considered preventive are covered 100% (no deductible). For an individual, the drug specific maximum allowable benefit for medications on your preventive prescription drug list filled at retail or mail order pharmacies is a 180 day supply every year. After you reach the drug specific maximum allowable preventive benefit, the deductible will apply.

If your medication is in a category not covered by the prescription drug benefit, please check with your medical carrier as it may be covered by that benefit.

Deductible/Coinsurance/Copayment

Each prescription order may be subject to a deductible and coinsurance/copayment. If the prescription order includes more than one covered drug, a separate coinsurance/copayment will apply to each covered drug.

The amount you pay for your prescription drugs will be no less than the minimum copay (unless the usual and

customary retail price is less than the minimum copay) and it will be no more than the lesser of your scheduled copayment/coinsurance amount or the Maximum Allowable Amount.

Please see the Schedule of Benefits for any applicable deductible and coinsurance/copayment. If you receive Covered Services from a non-network pharmacy, a separate deductible and coinsurance/copayment amount may also apply.

Day's Supply

The number of day's supply of a drug that you may receive is limited. The day's 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 day's supply allowed for a retail prescription under this Plan, talk with your retail pharmacist. If your prescription is through mail order (Express Scripts Home Delivery or Accredo), call Express Scripts 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 ID card.

Day's supply may be less than the amount shown in the Schedule of Benefits due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Tiers

Express Scripts classifies prescriptions by tiers: generic (Tier 1), preferred (Tier 2) and non-preferred (Tier 3). In a traditional medical plan (i.e. not an HDHP plan), your copayment/coinsurance amount may vary based on what tier the prescription drug has been classified by the Plan, including covered Specialty Drugs.

The determination of tiers is made based upon clinical information, and, where appropriate, the cost of the 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 certain clinical economic factors.

- **Tier 1** - generally includes generic prescription drugs.
- **Tier 2** - generally includes preferred brand name or generic drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other drugs.
- **Tier 3** - generally includes non-preferred brand name or generic drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other drugs in lower tiers.

For High Deductible Health Plans (HDHPs) the deductible/coinsurance amount does not vary based on tiers. Express Scripts provides various tool on their web site to help you find low cost alternatives when available.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the drug from a retail pharmacy, Home Delivery, Accredo's specialty pharmacy, or a non-network retail pharmacy. It is also based upon the Tier classification for the prescription drug or specialty drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The Plan retains the right at its 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 exclude or place other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable deductible and/or copayment/coinsurance for which you are responsible.

Your copayment, coinsurance and/or deductible amounts will not be reduced by any discounts, rebates or other funds received by Express Scripts from drug manufacturers or similar vendors. You are responsible for all deductibles and/or copayment/coinsurance amounts.

Schedule of Benefits

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

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

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

Lifetime Maximums: None

Pre-Existing Condition Limitations: None

IU Health High Deductible Health Plan (IU Health HDHP)

Service	In-Network Provider - Member Pays	Out-of-Network -Member Pays
Retail Prescriptions (Up to 30-day supply)	20% coinsurance after deductible[1] No coinsurance or deductible on most contraceptives Specialty Drugs[2] are not covered at Retail	No Coverage
Home Delivery Prescriptions (Up to 90-day supply) and Specialty Drugs[2]		

Deductible (combined In-Network R_x + Medical):

- $2,500 employee-only/$5,000 family
- Prescription drug copayments/coinsurance are subject to the deductible

Out-of-Pocket Limit (combined In-Network R_x + Medical):

- $3,000 employee-only/$6,000 family
- Prescription drug copayments /coinsurance are subject to the out-of-pocket limit; once the member and/or family out-of-pocket limit is satisfied, no additional copayments /coinsurance are required for the remainder of the calendar year.

1 No deductible on preventive prescriptions. For drug list, visit **hr.iu.edu/pubs/misc/preventive-rx.pdf**.
2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through Express Scripts Home Delivery.

Anthem PPO $500 Deductible Plan

Service	In-Network Provider - Member Pays	Out-of-Network -Member Pays
Retail Prescriptions (Up to 30-day supply)	• Tier 1[1] - $8 • Tier 2 - $25 • Tier 3 - $45	50% coinsurance plus amounts above the network's discounted price
Home Delivery Prescriptions (Up to 90-day supply) and Specialty Drugs[2]	• Tier 1[1] - $20 • Tier 2 - $62 • Tier 3 - $112	No Coverage

Three-tier Prescription Copayments: Within the brand and generic categories drugs are assigned a copayment "tier" based on cost and therapeutic value compared to other drugs. Tier 1 drugs are generics; Tier 2 are preferred brands; Tier 3 drugs include non-preferred brand drugs.

Deductible

- No deductible applies
- No copayment or deductible on most contraceptives

Out-of-Pocket Limit (In-Network R_x only)[3]

- $4,200 individual/$6,000 family

1 For a brand drug with a generic version available: member pays generic copayment plus the cost difference between the brand and generic.
2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through Express Scripts Home Delivery.
3 Medical expenses do not count toward prescription out-of-pocket maximum

Anthem PPO High Deductible Health Plan (Anthem PPO HDHP)

Service	In-Network Provider - Member Pays	Out-of-Network -Member Pays
Retail Prescriptions (Up to 30-day supply)	20% coinsurance after deductible[1] No coinsurance or deductible on most contraceptives Specialty Drugs[2] are not covered at Retail	40% after deductible
Home Delivery Prescriptions (Up to 90-day supply) and Specialty Drugs[2]		No Coverage

Deductible (combined In-Network R_x + Medical):

- $1,300 employee-only/$2,600 family
- Prescription drug copayments / coinsurance are subject to the deductible

Out-of-Pocket Limit (combined In-Network R_x + Medical):

- $2,600 employee-only/$5,200 family
- Prescription drug copayments /coinsurance are subject to the out-of-pocket limit; once the member and/or family out-of-pocket limit is satisfied, no additional copayments /coinsurance are required for the remainder of the calendar year.

1 No deductible on preventive prescriptions. For drug list, visit **hr.iu.edu/pubs/misc/preventive-rx.pdf**.
2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through Express Scripts Home Delivery.

Anthem IU Resident Plan

Service	In-Network Provider - Member Pays	Out-of-Network - Member Pays
Retail Prescriptions (Up to 30-day supply)	• Tier 1[1] - $10 • Tier 2 - $25 • Tier 3 - $75	50% coinsurance plus amounts above the network's discounted price with a $50 minimum
Home Delivery Prescriptions (Up to 90-day supply) and Specialty Drugs[2]	• Tier 1[1] - $25 • Tier 2 - $60 • Tier 3 - $180	No Coverage

Three-tier Prescription Copayments: Within the brand and generic categories drugs are assigned a copayment "tier" based on cost and therapeutic value compared to other drugs. Tier 1 drugs are generics; Tier 2 are preferred brands; Tier 3 drugs include non-preferred brand drugs.

Deductible

- No deductible applies
- No copayment or deductible on most contraceptives

Out-of-Pocket Limit (In-Network R_x only)[3]

- $5,200 individual/$9,000 family

1 For a brand drug with a generic version available: member pays generic copayment plus the cost difference between the brand and generic.
2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through Express Scripts Home Delivery.
3 Medical expenses do not count toward prescription out-of-pocket maximum

Anthem GA PPO Plan

Service	In-Network Provider - Member Pays	Out-of-Network - Member Pays
Retail Prescriptions (Up to 30-day supply)	• Tier 1[1] - $8 • Tier 2 - $25 • Tier 3 - $45	50% coinsurance plus amounts above the network's discounted price
Home Delivery Prescriptions (Up to 90-day supply) and Specialty Drugs[2]	• Tier 1[1] - $20 • Tier 2 - $62 • Tier 3 - $112	No Coverage

Three-tier Prescription Copayments: Within the brand and generic categories drugs are assigned a copayment "tier" based on cost and therapeutic value compared to other drugs. Tier 1 drugs are generics; Tier 2 are preferred brands; Tier 3 drugs include non-preferred brand drugs.

Deductible

- No deductible applies
- No copayment or deductible on most contraceptives

Out-of-Pocket Limit (In-Network R_x only)[3]

- $4,600 individual/$9,200 family

1 For a brand drug with a generic version available: member pays generic copayment plus the cost difference between the brand and generic.
2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through Express Scripts Home Delivery.
3 Medical expenses do not count toward prescription out-of-pocket maximum

Definitions

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

Coinsurance – The member's share of the cost of a covered service. For example, if a plan pays 80%, the member's co-insurance is 20%.

Copayment – A fixed amount paid for a covered service.

Deductible – The dollar amount of covered services an individual must pay each plan year before the plan begins reimbursement.

Deductible – The dollar amount of covered services an individual must pay each plan year before the plan begins reimbursement.

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

Home Delivery (Mail-Order) – Offers you a convenient means of obtaining maintenance medications by mail if you take prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Mail Service Pharmacy that has entered into a reimbursement agreement with the Plan, and sent directly to your home.

Maintenance Medications – Maintenance drugs are those generally taken on a long-term basis for conditions such as high blood pressure and high cholesterol. Examples of maintenance medications are Zocor and generic simvastatin, and Lipitor to lower cholesterol/lipids. What is the difference between long-term and short-term drugs? Long-term drugs are those taken on an ongoing basis, such as those used to treat high blood pressure or high cholesterol. Short-term drugs include antibiotics and other medications that you take for short periods of time.

Member – Any person covered under a plan, including the employee, a spouse or a child. Sometimes also referred to as enrollee or participant.

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

Pharmacy and Therapeutics (P&T) Committee – The P&T Committee consists of healthcare professionals whose primary purpose is to recommend policies in the evaluation, selection, and therapeutic use of drugs.

Prescription Order – A legal request, written by a provider, for a prescription drug or medication and any subsequent refills.

Prescription Legend Drug, Prescription Drug, or Drug A medicinal substance that is produced to treat illness or injury and is dispensed to patients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under the Plan.

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

Pharmacy - An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a physician's order. A pharmacy may be a network provider or a non-network provider.

Specialty Drugs - High cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through Express Scripts Home Delivery.

Grievance & Appeals Procedure

To formally lodge a complaint with Express Scripts, call 800-988-1794. Your initial response will addressed by a Customer Service Representative.

Your concerns will be logged into Express Scripts' Customer Service Contact System. Unresolved complaints will be escalated to a customer service resolution expert or to a supervisor. You can also request that your issue be escalated.

If your issue is still not resolved to your satisfaction, you have the right to file a formal appeal either verbally by phone, or by mail.

You will receive a follow up phone call and/or letter regarding resolution of your issue.

How to Reach Express Scripts

Internet

Express Scripts website at **www.express-scripts.com**.

Telephone

Call Express Scripts at 800-988-1794.

Mail

Express Scripts
P.O. Box 66564
St.Louis, MO 63166-6564

Special Services

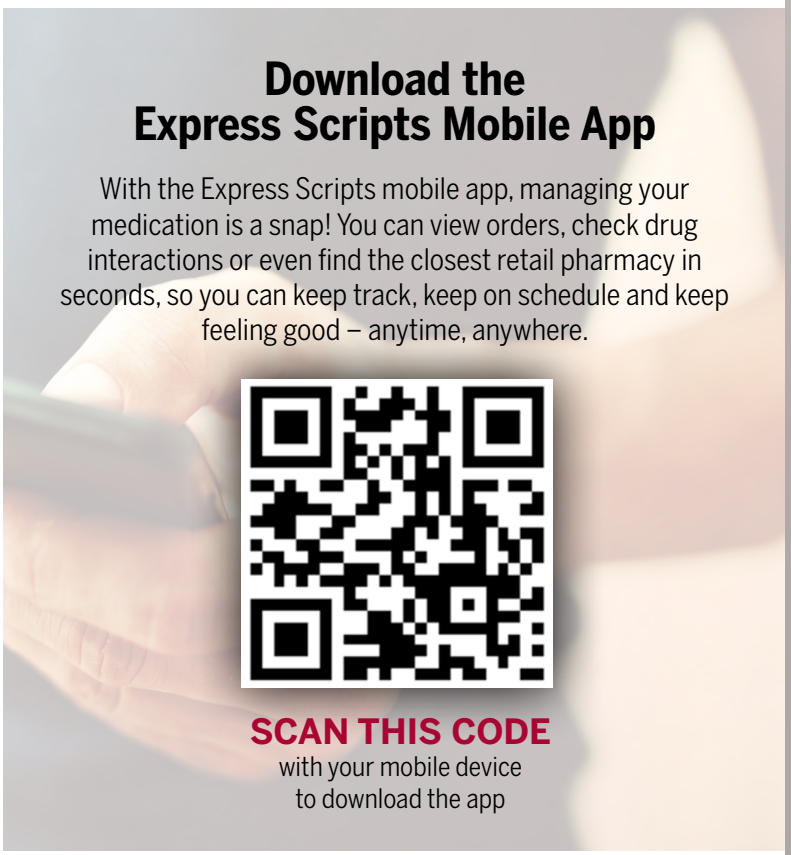
Call Accredo (Specilaty Pharmacy) at 800-988-1794.

Call a registered pharmacist at any time for emergency consultations at 877-841-5241.

Hearing-impaired members may use our 24/7 TDD number at 800-756-1089.

Visually impaired members may request that their mail-order precriptions include labels in large print or BRAILLE by calling 877-841-5421.

Notes



Indiana University Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date: April 14, 2003
Updated: October 15, 2016

As the Plan Sponsor of employee health care plans, Indiana University is required by law to maintain the privacy and security of your individually identifiable health information. We protect the privacy of that information in accordance with federal and state privacy laws, as well as the university's policy. We are required to give you notice of our legal duties and privacy practices, and to follow the terms of this notice currently in effect.

This notice applies to all employees covered under an IU-sponsored health plan, but particularly to employees enrolled in IU self-funded plans.

How The Plan May Use and Disclose Protected Health Information about Members

Protected Health Information (PHI) is health information that relates to an identified person's physical or mental health, provision of health care, or payment for provision of health care, whether past, present or future and regardless of the form or medium, that is received or created by the Plan in the course of providing benefits under these Plans.

The following categories describe different ways in which Indiana University uses and discloses health information. For each of the categories Indiana University has provided an explanation and an example of how the information is used. Not every use or disclosure in a category will be listed. However, all of the ways Indiana University is permitted to use and disclose information will fall within one of the categories.

Treatment

Health information may be reviewed to provide authorization of coverage for certain medical services or shared with providers involved in a member's treatment. For example, the Plan may obtain medical information from or give medical information to a hospital that asks the Plan for authorization of services on the member's behalf, or in conjunction with medical case management, disease management, or therapy management programs.

Payment

Medical information may be used and disclosed to providers so that they may bill and receive payment for a member's treatment and services. For example, a member's provider may give a medical diagnosis and procedure description on a request for payment made to the Plan's claim administrator; and the claim administrator may request clinical notes to determine if the service is covered. Similarly, a physician may submit medical information to a Business Associate for purposes of administering wellness program financial incentives. Medical information may also be shared with other covered entities for business purposes, such as determining the Plan's share of payment when a member is covered under more than one health plan.

Explanations of Payments are also mailed to the address of record for the employee, the primary insured.

Health Care Operations

Health information may be used or disclosed when needed to administer

the Plan. For example, Plan administration may include activities such as quality management, administration of wellness programs and incentives, to evaluate health care provider performance, underwriting, detection and investigation of fraud, data and information system management; and coordination of health care operations between health plan Business Associates. Genetic information will not be used or disclosed for health plan underwriting purposes.

Medical information may also be used to inform members about a health-related service or program, or to notify members about potential benefits. For example, we may work with other agencies or health care providers to offer programs such as complex or chronic condition management.

Individuals Involved in Your Care or Payment of Care

Unless otherwise specified, the plan may communicate health information in connection with the treatment, payment, and health care operations to the employee and/or any enrolled individual who is responsible for either the payment or care of an individual covered under the plan. Also, when a member authorizes another party in writing to be involved in their care or payment of care, the Plan may share health information with that party. For example, when an employee signs an authorization allowing a close friend to make medical decisions on his or her behalf, the Plan may disclose medical information to that friend.

Legal Proceedings, Government Oversight, or Disputes

Health information may be used or disclosed to an entity with health oversight responsibilities authorized by law, including HHS oversight of HIPAA compliance. For example, we may share information for monitoring of government programs or compliance with civil rights laws. Health information may also be disclosed in response to a subpoena, court or administrative order, or other lawful request by someone involved in a dispute or legal proceeding.

Health – Related Services and Research

Medical information may be used to inform members about an upcoming health-related service or program to help members better manage a chronic condition. For example, a diabetes or asthma management program.

Uses and Disclosures Requiring Your Written Authorization

In all situations, other than the categories described above, we will ask for your written authorization before using or disclosing personal information about you. The Plan will not share member information for marketing purposes, including subsidized treatment communications, or the sale of member information without written permission. Members can also opt-out of fundraising communications with each solicitation. If you have given us an authorization, you may revoke it at any time. This revocation does not apply to any uses or disclosures already made in reliance on the authorization.

Mental health information, including psychological or psychiatric treatment records, and information relating to communicable diseases are subject to special protections under Indiana law. Release of such records or information requires written authorization or an appropriate court order.

Member Rights Regarding Protected Health Information

Right to Inspect and Copy

Members have the right to inspect and obtain a copy of the Protected Health Information maintained by the Plan including medical records and billing records.

To inspect and copy PHI, members must submit in writing a request to the

plan administrator. Requests to inspect and copy PHI may be denied under certain circumstances. If a member's request to inspect and copy has been denied written documentation stating the reason for the denial will be sent to the member.

Right to Amend

Members have the right to request an amendment to PHI if they feel the medical information is incorrect for as long as the information is maintained. To request an amendment, members must submit requests, along with a reason that supports the request, in writing to the plan administrator.

The Plan may deny a member's request for an amendment if it is not in writing or does not include a reason to support the request. Additionally the Plan may deny a member's request to amend information that:

- Is not part of the information in which the member would be permitted to inspect or copy;
- Is not part of the information maintained by the Plan
- Is accurate and complete

Right to an Accounting of Disclosures

Members have the right to an accounting of PHI disclosures during the six years prior to the date of a request.

To request an accounting of disclosures, members must submit requests in writing to the plan administrator. Requests may not include permitted PHI disclosures made to carry out treatment, payment or health care operations included in the six categories listed above. The member's written request must include a date or range of dates and may not include any dates before the April 14, 2003, compliance date.

Right to Request Restrictions

Members have the right to request restrictions on certain uses and disclosures of Protected Health Information to carry out treatment, payment or health care operations. Members also have the right to request a limit on the information the Plan discloses to someone who is involved in the payment of your care; for example: a family member covered under the plan.

The Plan is not required to agree to your request. To request restrictions, members must submit requests in writing to the Plan. Requests must include the following: (1) information the member wants to limit; (2) whether the member wants to limit our use, disclosure or both; and (3) to whom the member wants the limit to apply, for example, disclosures to a spouse.

Right to Request Confidential Communications

Members have the right to request that the Plan communicate with them about health information in a certain way or at a certain location. For example, asking that the Plan to contact members only at work.

To request confidential communications, members must submit requests in writing to the health plan administrator and must include where and how members wish to be contacted. The Plan will accommodate all reasonable requests.

Right to Receive Breach Notification

If the Plan components or any of its Business Associates or the Business Associate's subcontractors experiences a breach of health information (as defined by HIPAA laws) that compromises the security or privacy of health information, members will be notified of the breach and any steps members should take to protect yourself from potential harm resulting from the breach.

Right to a Copy of This Notice

Members have the right to a copy of this Notice by e-mail. Members also have the right to request a paper copy of this notice. To obtain a copy, please contact the Privacy Administrator or visit *http://hr.iu.edu/benefits/privacynotice.pdf*

Changes Made to This Notice

The Plan reserves the right to change this Notice. The Plan reserves the right to make the revised or changed notice effective for Protected Health Information the Plan already has about members as well as any information received in the future. The Plan will make the notice available to members at all times.

Right to File a Complaint

If a member believes that their privacy rights have been violated, they may file a complaint to the Privacy Administrator with Indiana University's Health Care Plans, see contact information below.

Members may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue S.W., Washington, D.C., 20201; calling 1-877-696-6775, or visiting *http://www.hhs.gov/ocr/privacy/hipaa/ complaints/*.

Indiana University will not retaliate against any member for filing a complaint.

Contact Information

Members may contact the health plan with any requests, questions or complaints. We will respond to all inquiries within 30 days after receiving a written request. The Plan will accommodate all reasonable requests.

Privacy Administrator
Poplars E165
400 E. Seventh Street
Bloomington, Indiana 47405-3085
812-855-6709
enews@iu.edu

Personal Representatives

Members may exercise their rights through a personal representative. This person will be required to produce evidence of his/her authority to act on a member's behalf before they will be given access to PHI or allowed to take any action for a member. Proof of this authority may be one of the following forms:

- A power of attorney notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

IU HUMAN RESOURCES

400 East 7th Street, Poplars E165, Bloomington, IN 47405

812-856-1234 | hr.iu.edu

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