



INDIANA UNIVERSITY

PRESCRIPTION PLAN

ADMINISTERED BY CVS CAREMARK

FOR FULL-TIME ACADEMIC & STAFF EMPLOYEES,
IU RESIDENTS, AND STUDENT ACADEMIC APPOINTEES

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MANAGE YOUR PRESCRIPTIONS ONLINE

Log in to [Caremark.com](https://www.caremark.com) or the CVS Caremark app to:

- Request Mail Order refills quickly and conveniently
- Locate a network pharmacy
- Check drug availability and cost
- View prescription history
- Check drug interactions
- Learn more about the drugs you take
- Contact a pharmacist

To create your account, select “Register Now” on the home page of [Caremark.com](https://www.caremark.com) or the Caremark app.



FOREWORD

This Indiana University Prescription Plan 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.

CVS Caremark, the Pharmacy Benefit Manager (PBM), manages your prescription drug benefit under a contract with Indiana University ("the plan"). CVS Caremark maintains the Preferred Drug list (also known as a Formulary), manages a network of retail pharmacies, and operates the mail order and specialty drug pharmacies. CVS Caremark, 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 CVS Caremark Mail Order Pharmacy. The benefit covers most prescription drugs and some OTC items considered preventive under the Health Care Reform Act. Certain medications are subject to limitations and may require prior authorization for continued use.

The benefits described in this booklet are effective as of January 1, 2024.

QUESTIONS?

CVS Caremark may be contacted at:

CVS Caremark

P.O. Box 94467, Palatine, IL 60094-4467

T (866) 234-6952

[Caremark.com](https://www.caremark.com)

CVS Specialty: (800) 237-2767

24/7 TDD: (800) 231-4403

Indiana University may be contacted at:

IU Human Resources

2709 E. 10th Street, Ste 321

Bloomington, IN 47408

T (812) 856-1234 | **F** (812) 855-3409 | askhr@iu.edu

hr.iu.edu/benefits

OBTAINING PRESCRIPTION DRUG BENEFITS

RETAIL PHARMACY NETWORK

The CVS Caremark retail pharmacy network includes many chain and independent pharmacies including (but not limited to) CVS, Walmart, Sam's Club, Target, Kroger, and Williams Brothers. *Walgreens is not part of the network for IU plans.* To search for participating pharmacies visit [Caremark.com](https://www.caremark.com) or call 866-234-6952.

You can receive up to a 90-day supply of many non-specialty medications through network retail pharmacies. To fill your prescription at a network retail pharmacy, present your written prescription from your physician and your ID card to the pharmacist. Alternatively, some physicians send prescriptions to pharmacies electronically, in which case you will only need to present your ID card. You will be charged at the point of purchase for the applicable deductible and/or copay/coinsurance amounts, and the pharmacy will submit your claim for you.

New in 2024—Caremark Cost Saver Powered by GoodRx. With the Caremark Cost Saver program, IU medical plan members have automatic access to GoodRx pricing on participating generic medications. All you have to do is present your Anthem ID card at your preferred network pharmacy. The program automatically compares the covered benefit price with the GoodRx price (when available) and charges you the lower of the two. For HDHP members, the amount paid will automatically apply to your deductible and out-of-pocket maximum. For PPO \$500 Deductible plan members, the amount paid will automatically apply to your out-of-pocket maximum.

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, you can request reimbursement using the online claim system through your [Caremark.com](https://www.caremark.com) account, or by submitting a paper [Prescription Reimbursement Claim Form](#) to Caremark. An original itemized pharmacy receipt must be submitted with your claim that contains the following information. Please note that cash register receipts can only be accepted for diabetes supplies.

- Pharmacy name and address or Pharmacy NCPDP number
- Patient's name
- Prescription number
- Date the prescription was filled
- Medicine NDC number (drug number)
- Metric quantity
- Total charge
- Day's supply for your prescription

MAIL ORDER PHARMACY

You can receive up to a 90-day supply of many non-specialty maintenance medications through the Mail Order pharmacy. To begin Mail Order delivery, log in to your [Caremark.com](https://www.caremark.com) account or complete the [CVS Caremark Mail Order Form](#). You can mail written prescriptions from your physician, or have your physician fax or send the prescription electronically to CVS Caremark. You will need to submit the applicable deductible, coinsurance and/or copay amounts to CVS Caremark 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 [Caremark.com](https://www.caremark.com) or by calling 866-234-6952. 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. CVS Specialty offers therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs.

Specialty drugs are only covered through mail order, and must be filled through CVS Specialty, subject to a 30-day supply, with the applicable deductible, coinsurance, or copay. Some specialty medications may qualify for third-party copay assistance programs which could lower your out-of-pocket costs for those products. For more information or to order your specialty medications, visit [CVSSpecialty.com](https://www.cvspecialty.com) or call 800-237-2767.

OUT-OF-NETWORK RETAIL PHARMACY

If you visit a non-network retail pharmacy, you are responsible for payment of the entire amount charged and will need to submit a claim for reimbursement through CVS Caremark for consideration. You are responsible for the applicable deductible, coinsurance, or copay. This is based on the Maximum Allowable Amount as determined by CVS Caremark's 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 submit a prescription, the pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. CVS Caremark may contact your provider if additional information is required to determine whether Prior Authorization should be granted. CVS Caremark 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 provider. You have the right to appeal through the appeals process. The written notification of denial you receive provides instructions for filing an appeal.

You, your provider, or pharmacist, may check with CVS Caremark to verify covered prescription drugs, any quantity and/or age limits, prior authorization, or other requirements. To ask if a drug requires Prior Authorization, contact CVS Caremark at the Customer Service telephone number on the back of your ID card.

FORMULARY OR PREFERRED DRUG LIST

The formulary (also known as a "preferred drug list") is a list of commonly prescribed medications that may be covered by the plan. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of non-formulary medications, can help contain the increasing cost of prescription coverage while also providing a high quality of care.

You can request a copy of the formulary by calling CVS Caremark at 866-234-6952 or view the list online at [Caremark.com](https://www.caremark.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.

CVS Caremark 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. 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.

For questions or issues involving therapeutic drug substitutes, contact CVS Caremark at 866-234-6952.

STEP THERAPY

Step therapy protocol means that a member may need to use one type of medication—usually a more cost-effective one—before trying another. If their physician approves, the patient will be given the more cost-effective medication to try first. If the physician does not approve and prefers the 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. CVS Specialty offers:

- 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.

CVS Specialty must be used to fill specialty drug prescription orders, subject to a 30-day supply, with the applicable deductible, coinsurance, or copay. For more information or to order specialty medications, call 800-237-2767.

COVERED PRESCRIPTION DRUG BENEFITS

Prescription drugs, unless otherwise stated below, must be medically necessary and not experimental/investigative, to be covered. For certain prescription drugs, the prescribing physician may be asked to provide additional information before CVS Caremark 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. 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.

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:

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

NON-COVERED PRESCRIPTION DRUG BENEFITS

Non-covered prescription drug benefits include:

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

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

** Many tobacco cessation prescriptions and nicotine replacement products are considered preventive and covered at 100% (no deductible) by the plan. The maximum allowable benefit for tobacco cessation 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, coinsurance, or copay will apply.

DEDUCTIBLE/COINSURANCE/COPAY

Each prescription order may be subject to a deductible, coinsurance, or copay. If the prescription order includes more than one covered drug, a separate deductible, coinsurance, or copay will apply to each 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 no more than the lesser of your scheduled copay/coinsurance amount or the maximum allowable amount.

Please see the *Schedule of Benefits* for any applicable deductible, coinsurance, or copay. You are responsible for all deductible, coinsurance, and copay amounts. If you receive covered services from a non-network pharmacy, a separate deductible, coinsurance, or copay 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. 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.

If you are going on vacation and you need more than the supply allowed for a retail prescription under this plan, talk with your retail pharmacist. If your prescription is through Mail Order, call CVS Caremark Mail Order Pharmacy and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one month of early refills, contact IU Human Resources at askhr@iu.edu or 812-856-1234.

TIERS

CVS Caremark classifies prescriptions by tiers: generic (Tier 1), preferred (Tier 2) and non-preferred (Tier 3). In the case of the IU SAA PPO and IU Resident PPO plans, specialty medications are classified as a fourth tier (Tier 4).

Under a traditional medical plan, your copay/coinsurance amount may vary based on what tier the prescription drug has been classified by the plan, including covered specialty drugs. For high deductible health plans (HDHPs) the deductible/coinsurance amount does not vary based on tiers.

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	Drug Type	Cost
1	Generally includes generic prescription drugs.	\$
2	Generally includes preferred brand name or generic drugs that, based on their clinical information and cost considerations, are preferred relative to other drugs.	\$\$
3	Generally includes non-preferred brand name or generic drugs that, based on their clinical information and cost considerations, are not preferred relative to other drugs in lower tiers.	\$\$\$

PAYMENT OF BENEFITS

The amount of benefits paid is based upon whether you receive the drug from a retail pharmacy, Mail Order Pharmacy, 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.

No payment will be made by the plan for any covered service unless the negotiated rate exceeds any applicable deductible and/or copay/coinsurance for which you are responsible.

SCHEDULE OF BENEFITS

Please refer to the *Covered Services* section of this 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 described in this booklet. Benefits are based on a calendar plan year, January 1 to December 31. There are no lifetime maximums or pre-existing condition limitations.

ANTHEM HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Service	In-Network—Member Pays	Out-of-Network—Member Pays
Retail Prescriptions (Up to 90-day supply)	20% after deductible ¹ Specialty Drugs ² are not covered at retail. No deductible or coinsurance on most contraceptives.	Reimbursed up to the Maximum Allowed Amount or cost of prescription, whichever is less, after member cost-share (deductible or coinsurance).
Mail Order (Up to 90-day supply)		
Specialty Drugs² (Up to 30-day supply)		
Deductible (combined in-network and out-of-network prescription + medical): <ul style="list-style-type: none"> \$1,900 employee-only/\$3,800 all other coverage levels The deductible applies to all covered prescription costs (except preventive prescriptions). 		
Out-of-Pocket Maximum (combined in-network and out-of-network prescription + medical): <ul style="list-style-type: none"> \$3,800 employee-only/\$7,600 all other coverage levels All prescription drug costs paid by the employee apply towards the out-of-pocket maximum; once the member and/or family out-of-pocket limit is satisfied, no additional coinsurance is required for the remainder of the calendar year. 		
1 No deductible on preventive prescriptions. For drug list, visit hr.iu.edu/benefits/rx.html . 2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused. These are only covered through CVS Specialty.		

ANTHEM PPO \$500 DEDUCTIBLE PLAN

Service	In-Network—Member Pays	Out-of-Network—Member Pays
Tier 1 (Generic ¹)	Retail (30-day supply) — \$8 Retail (90-day supply) — \$20 Mail Order (90-day supply) — \$20	50% coinsurance plus amounts above the network's discounted price
Tier 2 (Preferred Brand)	Retail (30-day supply) — \$25 Retail (90-day supply) — \$62 Mail Order (90-day supply) — \$62	
Tier 3 (Non-Preferred Brand)	Retail (30-day supply) — \$45 Retail (90-day supply) — \$112 Mail Order (90-day supply) — \$112	
Specialty Drugs² (30-day supply)	Tier 1 (Generic ¹) — \$20 Tier 2 (Preferred Brand) — \$62 Tier 3 (Non-preferred Brand) — \$112	No Coverage
Three-tier Prescription Copays: Within the brand and generic categories drugs are assigned a copay "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: <ul style="list-style-type: none"> No deductible applies No deductible or copay on most contraceptives 		
Out-of-Pocket Maximum³ (in-network prescription only): <ul style="list-style-type: none"> \$7,050 individual/\$11,700 family maximum 		
1 For a brand drug with a generic version available: member pays generic copay 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 are only covered through CVS Specialty. 3 Medical expenses do not count toward prescription out-of-pocket maximum		

ANTHEM IU RESIDENT PPO PLAN

Service	In-Network—Member Pays	Out-of-Network—Member Pays
Tier 1 (Generic ¹)	Retail (30-day supply) — \$10 Retail (90-day supply) — \$25 Mail Order (90-day supply) — \$25	50% coinsurance plus amounts above the network's discounted price
Tier 2 (Preferred Brand)	Retail (30-day supply) — \$25 Retail (90-day supply) — \$60 Mail Order (90-day supply) — \$60	
Tier 3 (Non-Preferred Brand)	Retail (30-day supply) — \$75 Retail (90-day supply) — \$180 Mail Order (90-day supply) — \$180	
Tier 4 (Specialty Drugs ²)	Specialty ² (30-day supply only through Mail Order) — \$150	No Coverage
Four-tier Prescription Copays: Within the brand and generic categories drugs are assigned a copay "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; Tier 4 drugs include specialty drugs.		
Deductible: <ul style="list-style-type: none"> No deductible applies No deductible or copay on most contraceptives Out-of-Pocket Maximum³ (in-network prescription only): <ul style="list-style-type: none"> \$7,650 individual/\$13,500 family maximum 		
¹ For a brand drug with a generic version available: member pays generic copay 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 are only covered through CVS Specialty. ³ Medical expenses do not count toward prescription out-of-pocket maximum		

ANTHEM STUDENT ACADEMIC APPOINTEE (SAA) PPO PLAN

Service	In-Network—Member Pays	Out-of-Network—Member Pays
Tier 1 (Generic ¹)	Retail (30-day supply) — \$10 Retail (90-day supply) — \$20 Mail Order (90-day supply) — \$20	50% coinsurance plus amounts above the network's discounted price
Tier 2 (Preferred Brand)	Retail (30-day supply) — \$40 Retail (90-day supply) — \$80 Mail Order (90-day supply) — \$80	
Tier 3 (Non-Preferred Brand)	Retail (30-day supply) — \$75 Retail (90-day supply) — \$150 Mail Order (90-day supply) — \$150	
Tier 4 (Specialty Drugs ²)	Specialty ² (30-day supply only through Mail Order) — \$150	No Coverage
Four-tier Prescription Copays: Within the brand and generic categories drugs are assigned a copay "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; Tier 4 drugs include specialty drugs.		
Deductible: <ul style="list-style-type: none"> No deductible applies No deductible or copay on most contraceptives Out-of-Pocket Maximum³ (in-network prescription only): <ul style="list-style-type: none"> \$6,150 individual/\$12,300 family maximum 		
¹ For a brand drug with a generic version available: member pays generic copay 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 are only covered through CVS Specialty. ³ Medical expenses do not count toward prescription out-of-pocket maximum		

DEFINITIONS

Coinsurance

The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Copay

A fixed amount (for example \$8) paid for a covered service.

Deductible

A fixed amount that you must pay each policy year. This amount must be met before any benefits will be paid by your insurance.

Mail Order

A convenient means of obtaining maintenance medications by mail. Covered prescription drugs are ordered directly from the licensed Mail Order Pharmacy and shipped to your home.

Maintenance Medication

Drugs generally taken on a long-term basis for conditions such as high blood pressure and high cholesterol.

Member

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

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.

Prescription Legend Drug/Prescription Drug

A medicinal substance that is produced to treat illness or injury and is dispensed to patients. Under the Federal Food, Drug, and Cosmetic Act, such substances must bear a message on its original packaging label that states "Caution: Federal law prohibits dispensing without a prescription."

Specialty Drugs

High cost medications used to treat chronic, complex, and/or rare disease states generally requiring clinical assessment to optimize safety and adherence. Specialty drugs are often, but not only, given by injection or infusion, and may require special handling, storage, and/or administration. These drugs are covered only through CVS Specialty Pharmacy.

GRIEVANCE & APPEALS

To formally lodge a complaint with CVS Caremark, call 866-234-6952. Your initial response will be addressed by a Customer Service Representative.

Your concerns will be logged into CVS Caremark's 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, by mail, or by fax. You will receive a follow-up phone call and/or letter regarding resolution of your issue.

Telephone: File an appeal verbally at 866-234-6952.

Fax: File appeals via fax at 866-443-1172.



Indiana University Healthcare Plans 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: March 23, 2023

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 those 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 may be mailed to the physical or email 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 their 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.

Research

Health information may be used or shared for health research. Use of this information for research is subject to either a special approval process, or removal of information that may directly identify you.

Uses & 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 contact a member 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 themselves 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 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 new notice will be available on our web site, upon request, or by mail.

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 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 15 days after receiving a written request. The Plan will accommodate all reasonable requests.

Privacy Administrator
2709 E. 10th Street, Ste 321
Bloomington, IN 47408
812-856-1234 | askhr@iu.edu

Personal Representatives

Members may exercise their rights through a personal representative. This person will be required to produce evidence of their authority to act on a member's behalf before being 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

T (812) 856 1234 | **F** (812) 855 3409
askhr@iu.edu
hr.iu.edu/benefits

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