AMENDMENT NUMBER ONE TO THE
IVY TECH COMMUNITY COLLEGE HEALTH AND DENTAL CARE PLAN

THIS AMENDMENT NUMBER ONE is adopted by Ivy Tech Community College of Indiana as of the date executed below.

WHEREAS, Ivy Tech Community College of Indiana ("Ivy Tech") established the Ivy Tech Community College Health and Dental Care Plan ("Plan") and most recently amended and restated the Plan effective as of January 1, 2017.

WHEREAS, the Plan is hereby amended by this Amendment Number One to include updates to the Plan, generally effective January 1, 2018.

NOW, THEREFORE, the Plan is hereby amended, effective as of January 1, 2018 unless otherwise provided herein, as follows:

1. The prescription drug benefit coverage under the Plan is administered by CVS Caremark effective as of January 1, 2018. Accordingly, all references throughout the Plan to Express Scripts (the Plan's prior pharmacy benefits manager) are revised to read CVS Caremark.

2. The **Prescription Drugs** schedule of benefits under the Standard Option, and the notes that follow, which are all reflected on pages 9-11 of the Plan, are revised as follows:

PRESCRIPTION DRUGS[3]

Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

	Copayment/Coinsurance/Maximums
Retail Pharmacy (Network and Non-Network)	30 days
Mail Service	90 days
Retail Specialty Pharmacy (Network & Non-Network) and Specialty Mail Service	30 days
Network Retail Pharmacy Prescription Drug	
Tier 1 Prescription Drugs Copayment per Prescription Order	$10
Tier 2 Prescription Drugs Copayment per Prescription Order	$45
Tier 3 Prescription Drugs Copayment per Prescription Order	$90
Specialty Prescription Drugs Copayment per Prescription Order	10% Coinsurance up to $150
CVS Mail Service Program Prescription Drug	
Tier 1 Prescription Drugs Copayment per Prescription Order	$20
Tier 2 Prescription Drugs Copayment per Prescription Order	$112.50
Tier 3 Prescription Drugs Copayment per Prescription Order	$225
Specialty Prescription Drugs	10% Coinsurance up to $300

Copayment per Prescription Order	
Smoking Cessation Prescription Drugs	$0 Copayment and Deductible – Network 50% Coinsurance – Non-Network - Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Coinsurance
Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Copayment/Coinsurance:	50% Coinsurance[4]
Preventive Medications	0% Deductible, Copayment, Coinsurance – Network 50% Coinsurance ($30 copay minimum) – Non-Network - Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Copayment/Coinsurance

Prescription Drug Notes:

- Prescription drug copayments do not apply toward the medical Deductible.
- No prescription drug Copayment/Coinsurance applies to certain diabetic and asthmatic supplies, up to the Maximum Allowable Amount, when obtained from a Network Pharmacy. These supplies are covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to prescription drug Copayments/Coinsurance.
- If a Covered Person receives a Prescription Order coded as "Generic Drug available" by a Physician and chooses to fill the Prescription Order with a more costly Brand Name Drug, the Covered Person is responsible for the difference in cost between the Generic Drug and the Brand Name Drug. Please see the Prescription Drug Benefits section for more detailed information.
- With respect to Non-Oral Prescription Contraceptives, contact Anthem regarding level of coverage.

General Notes:

- All Deductibles and Coinsurance apply toward the Out-of-Pocket Limit, including prescription drugs. (Excludes Non-Network Human Organ and Tissue Transplants.)
- Deductible(s) apply only to Covered Services listed with a percentage (%) Coinsurance. However, the Deductible does not apply to Emergency Room Services at a Hospital where a percentage (%) Coinsurance applies to other Covered Services.
- Network and Non-Network Deductibles, Copayments, Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.
- Dependent age: to the end of the month in which the Child reaches age 26.
- Specialty Care Physician Copayment is applicable to all Specialty Care Physicians excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the Plan.
- When allergy injections are rendered with a Physicians Home Visit and Office Visit, only the Office Visit cost share applies.
- No Copayment/Coinsurance means no Deductible/Copayment/Coinsurance up to the Maximum Allowable Amount. 0% means no Coinsurance up to the Maximum Allowable Amount. However, when choosing a Non-Network Provider, the Covered Person is responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount.

- We encourage you to contact the Mental Health Subcontractor to assure the use of appropriate procedures, setting and Medical Necessity.

3. The **Prescription Drugs** schedule of benefits under the Choice Option, and the notes that follow, which are all reflected on pages 15-16 of the Plan, are revised to read as follows:

PRESCRIPTION DRUGS

Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

	Copayment/Coinsurance/Maximums
Retail Pharmacy (Network and Non-Network)	30 days
Mail Service	90 days
Retail Specialty Pharmacy (Network & Non-Network) and Specialty Mail Service	30 days
Network Retail Pharmacy Prescription Drug	
Tier 1 Prescription Drugs Copayment per Prescription Order	15% Coinsurance
Tier 2 Prescription Drugs Copayment per Prescription Order	15% Coinsurance
Tier 3 Prescription Drugs Copayment per Prescription Order	15% Coinsurance
Specialty Prescription Drugs Copayment per Prescription Order	15% Coinsurance
CVS Mail Service Program Prescription Drug	
Tier 1 Prescription Drugs Copayment per Prescription Order	15% Coinsurance
Tier 2 Prescription Drugs Copayment per Prescription Order	15% Coinsurance
Tier 3 Prescription Drugs Copayment per Prescription Order	15% Coinsurance
Specialty Prescription Drugs Copayment per Prescription Order	15% Coinsurance
Smoking Cessation Prescription Drugs	$0 Copayment and Deductible – Network 45% Coinsurance – Non-Network - Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Coinsurance
Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Copayment/Coinsurance:	45% Coinsurance (minimum $30)[4]
Preventive Medications	0% Deductible, Coinsurance –Network 45% Coinsurance – Non-Network - Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Coinsurance

Prescription Drug Notes:

- Prescription drug Coinsurance does not apply toward the medical Deductible.

- Deductible applies to all prescription drug expenses, except for preventive medications in network. Once the Deductible is met, the appropriate Copayment/Coinsurance applies.

- No prescription drug Coinsurance applies to certain diabetic and asthmatic supplies, up to the Maximum Allowable Amount, when obtained from a Network Pharmacy. These supplies are covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to prescription drug Coinsurance.
- If a Covered Person receives a Prescription Order coded as "Generic Drug available" by a Provider and chooses to fill the Prescription Order with a more costly Brand Name Drug, the Covered Person is responsible for the difference in cost between the Generic Drug and the Brand Name Drug. Please see the Prescription Drug Benefits section for more detailed information.
- With respect to Non-Oral Prescription Contraceptives, contact Anthem regarding level of coverage.

General Notes:

- All Deductibles and Coinsurance apply toward the Out-of-Pocket Limit, including prescription drugs. (Excludes Non-Network Human Organ and Tissue Transplants.)
- Deductible(s) apply to Covered Services listed with a percentage (%) Coinsurance.
- Network and non-network Deductibles, Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.
- Dependent age: to the end of the month in which the Child reaches age 26.
- No Copayment/Coinsurance means no Deductible/Copayment/Coinsurance up to the Maximum Allowable Amount. 0% means no Coinsurance up to the Maximum Allowable Amount. However, when choosing a Non-Network Provider, the Covered Person is responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount.
- We encourage you to contact the Mental Health Subcontractor to assure the use of appropriate procedures, setting and Medical Necessity. Refer to Schedule of Benefits for limitations.

4. The definition of **Pharmacy and Therapeutics (P&T) Committee**, reflected on page 26 of the Plan, is deleted.

5. The section titled **Prescription Drug Benefits**, reflected on pages 52-58 of the Plan, is revised in its entirety to read as attached.

6. In all other respects, the Plan shall remain unchanged.

This Amendment Number One is duly executed as of the date and year written below.

IVY TECH COMMUNITY COLLEGE OF INDIANA

By: Julie Lortal Rowland

Print: Julie Lortal Rowland

Title: Sr VP for Human Resources

Date: 3/30/2018

Prescription Drug Benefits

Pharmacy Benefits Manager

The pharmacy benefits coverage available to you under the Plan is managed by CVS Caremark, the pharmacy benefits management (PBM) company with which the Plan contracts to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Specialty Pharmacy, and a Mail Service Program. It also provides clinical management services.

The PBM's role includes making recommendations and updates to the Plan's Formulary, which is a list of covered Prescription Drugs. The Formulary is subject to periodic review and amendment. Inclusion of a Drug or related item on the Formulary is not a guarantee of coverage under the Plan. The Formulary changes periodically and should be verified at the time a medication is prescribed to ensure it remains covered under the Plan. Refer to the information in this Prescription Drug Benefits section for details on coverage, limitations, and exclusions.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Medical Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the Plan can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs. Covered Medical Services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

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. For a current list of the Drugs requiring Prior Authorization, please contact the PBM at the Customer Service telephone number on your ID card.

At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system and the pharmacist is instructed to contact the PBM for Prior Authorization. The PBM communicates the results of the decision to the pharmacist. The PBM may contact your prescribing Physician if additional information is required to determine whether Prior Authorization should be granted.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the "Covered Person Internal Claim Appeals and External Review Process" section of this Plan.

Therapeutic Substitution of Drugs is a program approved and managed by the PBM. This is a voluntary program designed to inform Covered Persons and Physicians about possible alternatives to certain prescribed drugs. The PBM may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic drug substitutes, contact the PBM by calling the Customer Service telephone number on your ID card. The therapeutic drug substitutes list is subject to periodic review and amendment.

Step Therapy Protocol means that a Covered Person may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Covered Persons access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the Physician will need to provide the PBM with the following information:

- Covered Person name and ID number

- Diagnosis
- Drug name
- Reason for appeal
- Physician name, specialty, address and phone number

Specialty Pharmacy

CVS Caremark Specialty Pharmacy is available to Covered Persons who use Specialty Drugs.

"Specialty Drugs" are Prescription Legend Drugs which:

- Are only approved to treat limited patient populations, indications or conditions;
- Are normally injected, infused or require close monitoring by a Physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the drug difficult to obtain through traditional pharmacies.

Specialty Drugs may only be filled at a CVS Caremark Specialty Pharmacy, but you may pick-up the order at a retail CVS Pharmacy, as well as by Mail Order, subject to the applicable Coinsurance or Copayment shown in the Schedule of Medical and Prescription Drug Benefits.

Covered Prescription Drug Benefits

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Female contraceptive drugs, when obtained through an eligible Pharmacy.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes) are covered without any Copayment or Coinsurance. Contact the PBM to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered under Covered Medical Services as Medical Supplies, Durable Medical Equipment, and Appliances, instead of under Prescription Drug benefits.
- Injectables.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.
- Smoking cessation Prescription Drugs.
- Over-the-counter (OTC) smoking cessation drugs, if prescribed by a Physician.
- Prescribed anorexiants (effective May 15, 2018, Prior Authorization is required).
- Human Growth Hormone, with Prior Authorization.
- Treatment of Onchomycosis (toenail fungus), with Prior Authorization.

Non-Covered Prescription Drug Benefits

- Drugs, devices and products, or Prescription Legend Drugs with over-the-counter (OTC) equivalents and any drugs, devices or products that are therapeutically comparable to an OTC drug, device, or product, unless specifically covered.

- Off label use, except as otherwise prohibited by law or as approved by the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This exclusion does not apply to Drugs used in conjunction with a Diagnostic Service, with chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; such Drugs are Covered Medical Services.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin and smoking cessation drugs.
- Drugs in quantities which exceed the limits established by the Plan, or which exceed any age limits established by the Plan.
- Any New FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA new drug approval or other applicable FDA approval. The Plan may, at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over-the-counter (OTC) drugs, devices or products, they are not Covered Medical Services.
- Compound Drugs.
- Certain Prescription Legend Drugs are not Covered Medical Services when any version or strength becomes available over the counter. **Please contact the PBM for additional information on these drugs.**

Please also see the Exclusions section of this Plan for other Non-Covered Medical Services.

Deductible/Coinsurance/Copayment

Each Prescription Order is subject to a Coinsurance or Copayment shown in the Schedule of Medical and Prescription Drug Benefits. If the Prescription Order includes more than one covered Drug, a separate Coinsurance or Copayment will apply to each Drug. Your Prescription Drug Coinsurance or Copayment will be the lesser of your scheduled Coinsurance or Copayment amount or the Maximum Allowable Amount. Please see the Schedule of Medical and Prescription Drug Benefits for any applicable Coinsurance or Copayment.

Days' Supply

The number of days' supply of a Drug is limited as shown in the Schedule of Medical and Prescription Drug Benefits. If you are going on vacation and you need more than the days' supply permitted under the Plan, ask your pharmacist to call the PBM and request an override for one additional refill. This will

allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on your Identification Card.

Coverage Tiers

Your Copayment or Coinsurance amount may vary based on whether the Prescription Drug has been classified by the Plan as a first, second, or third "tier" Drug. The determination of tiers is made by the PBM on behalf of the Plan 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 (OTC) alternatives; and (where appropriate) certain clinical economic factors.

- Tier 1 generally includes Generic Prescription Drugs.
- Tier 2 generally includes 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 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.

Generic Drug Encouragement

If a Covered Person receives a Prescription Order coded as "Generic Drug available" by a Provider and chooses to fill the Prescription Order with a more costly Brand Name Drug, the Covered Person is responsible for the difference in cost between the Generic Drug and the Brand Name Drug, as well as the Copayment for the Brand Name Drug.

The Plan may, from time to time, offer incentives to encourage the use of Generic Drugs. This may involve waiving a Copayment or Coinsurance for certain Generic Drugs for a period of time or other incentives.

Payment of Benefits

The amount of benefits paid is based upon whether you fill a Prescription Order at a Network Pharmacy, including the CVS Caremark Specialty Pharmacy, at a Non-Network Pharmacy, or through the Mail Service Program. It is also based upon which tier the Prescription Drug or Specialty Drug has been classified. Please see the Schedule of Medical and Prescription Drug Benefits for the applicable amounts, and for applicable limitations on number of days' supply.

The PBM, on behalf of 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 Medical and Prescription Drug Benefits. Your Copayment, Coinsurance, and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

Network Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment or Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you pay the full charge, ask your pharmacist for an itemized receipt and submit it to the PBM with a written request for refund.

Specialty Drugs – You or your Physician can order your Specialty Drugs directly from the CVS Caremark Specialty Pharmacy. You may then pick-up your Specialty Drugs from a Network Pharmacy or through the Mail Order Program.

Non-Network Pharmacy – You are responsible for Payment of the entire amount charged by the Non-Network Pharmacy. You must submit a Prescription Drug claim form to the Plan for reimbursement consideration. These forms are available from the PBM and/or Ivy Tech. You must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to the Plan. The itemized receipt must show:

- name and address of the Non-Network Pharmacy;
- patient's name;
- prescription number;
- date the prescription was filled;
- name of the Drug;
- cost of the prescription;
- quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Medical and Prescription Drug Benefits. This is based on the Maximum Allowable Amount as determined by the PBM's normal or average contracted rate with Network Pharmacies on or near the date of service.

Mail Service Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service Pharmacy. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance, and/or Copayment amounts to the Mail Service Pharmacy when you request a prescription or refill.

Preventive Medications

Certain preventive medications (including Prescription Drugs) are considered Covered Medical Services and are not subject to the Copayment or Coinsurance, to the extent applicable.

In addition to a healthy lifestyle, preventive medications can help people avoid many illnesses and conditions and support the goal of ongoing good health.

In order to be covered, all preventive medications (i) require a prescription from a Physician (even if the medication is available without a prescription), and (ii) must be Medically Necessary. Examples of covered preventive medications include:

- Aspirin (for males ages 50-59; for females, ages 12-59)
- Smoking cessation products **[see Preventive Care Services]**
- Fluoride (through age 5)
- Folic acid for females through age 55.
- Female contraceptives
- Vaccines (prescription drug products recommended by the Advisory Committee (CDC) on Immunization Practices)
- Vitamin D (for individuals at least 65 years of age in community dwellings)
- Statins (ages 40-75, low to medium intensity)

The medications are categorized based on the medical conditions that they are used to prevent. This is not an all-inclusive list; only examples of medicines in each category are listed. Coverage prior to the Deductible being met may not be provided for every dosage form of a listed medication. This list is periodically reviewed by clinical experts. Medications may be added to or removed from the list based on different factors, including the intended purpose of the medication and its availability.