Health Plans

MSD of Wayne Township

Plan Document and Summary Plan Description

Amended and Restated Effective January 1, 2017

Administered by IU Health Plans

IU Health Plans

Summary Plan Description for MSD of Wayne Township Team Members

Your Guide to Quality Healthcare Services and Healthier Living

Welcome to IU Health Plans, the health Plan offered to Team Members of MSD of Wayne Township. As a team member of MSD of Wayne Township, you have access to some of the very best healthcare services in the world. To help you understand the healthcare services and benefits available to you through this Plan, MSD of Wayne Township developed this *Summary Plan Description* (SPD), which is updated as necessary.

The Summary Plan Description is the health Plan document. There are no other documents to reference when determining Plan coverage. We encourage you to take the time to read it carefully and to access it for future reference. Summary Plan Description information is available on the IU Health Plans' website: iuhealthplans.org.

You will find helpful information about:

- Network Providers;
- Covered benefits and services, limitations and exclusions;
- Administrative and enrollment procedures;
- The medical benefits administrator and coordination of benefits;
- Medical Management services to ensure quality care;
- The Prescription Drug benefit and eligibility;
- Pharmacy and benefits management programs; and
- Member services.

Refer to this document for detailed information and definitions of the terms used throughout the SPD. Be sure to bookmark this document for quick reference when you need it. If you have any questions, contact IU Health Plans Member Services for information: 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. The website is: iuhealthplans.org.

This is your guide to quality healthcare services and healthier living. Quality healthcare is everybody's responsibility. We encourage you to pursue a lifestyle of healthy living. MSD of Wayne Township Employee Benefits Plan looks forward to assisting you with your healthcare needs.

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Section One:

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **MSD of Wayne Township** (the "Company" or the "Plan Sponsor") as of January 1, 2017, hereby sets forth the provisions of the MSD of Wayne Township Employee Benefit Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

MSD of Wayne Township

By: _____

Name: _____

Date: _____ Title: _____

Section Two:

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are self-funded with contributions from Covered Persons and the Plan Sponsor." Covered Persons in the Plan may be required to contribute toward their benefits. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Covered Persons in the Plan to the maximum feasible extent.

The Plan Sponsor will provide to Covered Persons a Plan Document and a Summary Plan Description; The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the **MSD of Wayne Township** and may be reviewed at any time during normal working hours by any Covered Person.

General Plan Information

Name of Plan:	**MSD of Wayne Township Employee Benefit Plan**
Plan Sponsor:	**MDS of Wayne Township** **1220 S. High School Rd.** **Indianapolis, IN 46241** **Phone: 317-988-8656** **Email: shandy.brickler@waynek12.in.us**
Plan Administrator: **(Named Fiduciary)**	**MSD of Wayne Township** **1220 S. High School Rd.** **Indianapolis, IN 46241** **Phone: 317-988-8656**

Plan Sponsor ID No. (EIN): 35-1072270

Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**Certain Federal and State Laws**
Plan Year:	**January 1 through December 31**
Plan Number:	**501**
Plan Type:	**Medical** **Prescription Drug**
Medical Benefits Administrator	**IU Health Plans** **950 N. Meridian St., Ste. 200** **Indianapolis, IN 46204** **Phone: (800) 873-2022** **Fax: (317) 963-9800** **Website: www.iuhealth.org**
Participating Employer(s):	**MSD of Wayne Township**
Agent for Service of Process:	**MDS of Wayne Township** **1220 S. High School Rd.** **Indianapolis, IN 46241** **Phone: 317-988-8600**

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of

the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Mental Health Parity

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), , this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Applicable Law

This is a self-funded benefit plan for a governmental entity and/or subdivision that is exempt from the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan.

Future of MSD of Wayne Township Employee Benefits Plan

MSD of Wayne Township intends to continue the Plan. However, MSD of Wayne Township reserves the right to modify, suspend, or terminate the Plan, or any part of it, any time. The decision to change or end the Plan may be due to changes in federal or state laws that govern Employee benefits, the requirement of the Internal Revenue Code or any other reason. A Plan change may provide for the transfer of Plan assets and liabilities to another plan, split a plan into two or more parts, decrease benefits, or add/increase contributions for coverage. If such steps are planned, you will be given notice. You will also be informed of the effect of any material change in the Plan or of your rights to benefits.

Section Three:

Self-Funded HMO Plan Design

This Plan is a Self-Funded Plan, with design features similar to an HMO. IU Health Plans' providers and facilities deliver high quality, seamless care. If you are in this Plan, in general, the Plan only pays medical benefits for care delivered by IU Health Plans Providers.

Under the following circumstances, the Self-Funded HMO Plan benefit level will apply for certain Covered Services rendered by a provider who does not participate in the IU Health Plans Network:

- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the IU Health Plans service area.
- If a Plan Participant has a Medical Emergency requiring immediate care.
- If a Plan Participant receives Physician or anesthesia services from a Non-Network Radiologist, ER Physician, Pathologist or Anesthesiologist at an in-network facility.
- If a Plan Participant has lab work taken by an IU Health Plans Physician, but the Physician sends it to a Non-Network facility for evaluation.

High Deductible Health Plan

HDHP Plans allow employees to contribute funds to a personal Health Savings Account (HSA) on a pre-tax basis, which can be used to pay for eligible medical expenses until the Deductible/Out-of-Pocket Maximum is met.

An employee enrolled in a HDHP Plan is responsible for paying the full cost of services for themselves and their enrolled Dependents, including prescriptions—with the exception of specific qualified preventive care services and preventive prescriptions—until the annual HDHP Deductible is met. Once the Deductible is met the Plan begins to pay Coinsurance based on where the services are received. (Coinsurance is a cost sharing feature in which the employee and the health Plan each pay a certain percentage of the cost of care until the employee's Out-Of-Pocket Maximum is reached.)

Contributions to HSAs are limited by federal regulations. The limits for 2017, which include both employee and Employer contributions, are $3,400 for individuals and $6,750 for families. Unused HSA funds roll over from year to year and stay with the individual through retirement, even if the individual should leave MSD of Wayne Township or no longer participate in the Plan. Unlike a traditional healthcare flexible spending account (FSA), unused HSA balances are not lost at the end of the year. This provides individuals the opportunity to accumulate funds for future qualified expenses. HSA funds can also be invested for the possibility of greater earning potential.

Per federal regulations, HSA Plan members are not eligible for enrollment in another Plan (such as, Medicaid, Medicare or TriCare) and may not participate in a traditional healthcare flexible

spending account (FSA). A "limited-purpose FSA" is available to pay for eligible, non-reimbursed dental and vision costs.

Contact your local benefits office for more information on the HDHP.

Networks When Out of the Service Area (Only Applicable to HDHP Plans)

If an urgent medical problem occurs outside the State of Indiana and you want to identify a Provider, contact PHCS Healthy Directions to locate a nearby Facility (www.multiplan.com) or look for the toll-free number on the back of your Identification (ID) Card. Remember that any follow up or routine care needs to be delivered by Network Providers for the highest level of benefit.

If a life-threatening Emergency occurs, no matter where you are, call 911 for immediate help or go to the nearest medical Facility for treatment. Remember to advise your Primary Care Physician (PCP) for coordination of follow-up care.

Provider Directories

The most up-to-date listing of Network Providers, Physicians, Hospitals, and affiliated Facilities is available through the IU Health Plans website: iuhealthplans.org. Be sure to check the Provider directory listings of Physicians and Facilities before services are obtained as the list changes from time to time. If you do not have regular access to a computer, contact IU Health Plans Member Services, 800.873.2022 or 317.816.5170 and a member services representative will assist you.

Section Four:

MSD of Wayne Township Healthcare Coverage

MSD of Wayne Township Employee Benefits Plan is committed to providing comprehensive healthcare coverage for all Covered Persons. The portion the Covered Person pays for health coverage through premium deduction and out-of-pocket costs differs based on the Plan you select.

The medical benefits through MSD of Wayne Township Employee Benefits Plan are administered by IU Health Plans. IU Health Plans Member Services may be contacted at 800.873.2022 or 317.816.5170.

IU Health Plans encourages each Covered Person to develop a relationship with a Primary Care Physician (PCP). Physician specialties considered primary include: Family Practice, General Practice, Internal Medicine, and Pediatrics for Dependents 18 years and younger. This will provide you with the advantage of having a Physician knowledgeable about your healthcare needs who can provide:

- Preventive healthcare services'
- Care if you become ill;
- Advice regarding the need to see a Specialist.

With a PCP, your care is coordinated by one Physician and you can be assured that you are receiving the best possible healthcare available.

Network Providers

A Network Provider is a Physician, Hospital, Facility or ancillary service Provider who has an agreement with the Network to accept a reduced rate (Negotiated Rate) for providing Covered Services to Covered Persons. Because the Covered Person and the Plan save money when services, supplies or treatment are obtained from Providers Participating in the Network, benefits are usually greater than those available when using the services of a Non-Network Provider. A complete list of Network Providers is available on the IU Health Plans' website: iuhealthplans.org in the provider directory section.

Referrals to Network Specialists for Covered Services are not required. However, coverage is subject to applicable Copayments, Coinsurance and Deductibles. Remember to advise your Primary Care Physician about services received from a Specialist so he/she can maintain your complete medical record.

The Network Provider may bill the Covered Person in the following instances:

1. Coinsurance amounts as reported on the Explanation of Benefits (based on the applicable percentage of the reimbursement to providers), Copayments and Deductibles as reported on the Explanation of Benefits;
2. Penalties imposed on a Covered Person by the Plan for the Covered Person's failure to comply with utilization management processes;

3. Services which are determined not to be Medically Necessary;
4. Non-Covered Services; and
5. Services for which the Plan fails to pay within the time for payment as set forth in the Network agreement or according to state law. (See Claims section for additional information.)

Network Providers may NOT bill the Covered Person in the following instances:

1. In the provision of Medically Necessary Covered Services, except Copayments, Deductibles and Coinsurance;
2. The difference between a Network Provider's billed charges and the Plan's Negotiated Rate;
3. For penalties imposed on Network Providers by insurers as a result of the Network Provider's failure to comply with the Plan's procedures of utilization management, after all final Appeals have been exhausted.

Non-Network Providers

A Non-Network Provider does not have an agreement with the Network Provider Organization and has not agreed to the Negotiated Rate when providing Covered Services. With Non-Network Providers, the Plan pays a lower amount than for Network Providers. The Plan uses only the Customary and Reasonable amount as the fee for the Covered Service, supply or treatment. The Covered Person may be billed for the remainder of billed charges by the Non-Network Provider. Deductibles and Coinsurance also apply.

Referrals

Referrals are not needed to see a Provider for Covered Services. It is the Covered Person's responsibility to ensure services are performed by Network Providers to receive the highest level of payment for Covered Services. The following list of exceptions includes services, supplies or treatments provided by a Non-Network Provider that will be covered as if provided by a Network Provider:

- Non-Network anesthesiologist if the operating Facility is a Participating Provider.
- Radiologist or pathologist services for interpretation of x-rays and laboratory tests provided by a Non-Network Provider when the Facility participates in the Network.
- While confined to a Network Hospital, the Network Physician requests a consultation from the Non-Network Provider.
- Medically Necessary services, supplies and treatments not available through any Network Provider.
- Ambulance services.
- Non-Network assistant surgeon charges if the operating surgeon is a Network Provider.
- Urgent Care treatment.
- Emergency treatment at a Network Facility by a Non-Network Provider. If the Covered Person is admitted to the Hospital after such Emergency treatment, Covered Services shall be payable at the Network Provider level.

Benefits

This section provides a thorough explanation of MSD of Wayne Township Employee Benefits Plan's benefits, including Behavioral Health benefits. Behavioral Health includes Mental Health and Chemical Dependency services. Note that Covered Services must be Clinically Appropriate and are subject to coverage limits and exclusions.

MSD of Wayne Township Employee Benefits Plan has the right to review all claim reimbursements retrospectively and adjust payment according to its guidelines. This means the Covered Person may be financially accountable for services after they have been rendered.

MSD of Wayne Township Employee Benefits Plan Summary of Benefits chart that follows summarizes coverage levels, Deductibles, Copayments, Coinsurance, Out-of-Pocket Maximum information and limits to Covered Services. Further explanation of benefits coverage, exclusions and limitations appear after the chart.

Benefits Table Summary

Medical Benefit

The Plan pays the percentage listed on the following pages for Covered Charges Incurred by a Covered Person during the calendar year after the individual or family Deductible has been satisfied and until the individual or family Out-of-Pocket Maximum has been reached. Thereafter, the Plan pays 100 percent (100%) of Incurred Covered Charges for the remainder of the calendar year or until the Maximum Benefit has been reached (where applicable).

All services are subject to Deductible unless otherwise indicated.

Services of Non-Network Physicians or Facilities unless due to a medical Emergency or with a Plan-approved referral are payable at a reduced rate. The Plan uses only the Customary and Reasonable amount as the fee for the Covered Service, supply or treatment when utilizing Out-of-Network Providers. The Covered Person may be billed for the remainder of billed charges by the Non-Network Provider. Deductibles and Coinsurance also apply.

Medical Benefit Description	Self-Funded HMO Plan	HDHP Low	HDHP High
Provider Networks Plan approved referrals are required for payment of certain services. See Prior Authorization listing.	IU Health Plans	IU Health Plans PHCS Healthy Directions for Travel and Out of Area	IU Health Plans PHCS Healthy Directions for Travel and Out of Area
Annual Deductible Individual/Family (Calendar Year)	**In Network** = $500/$1,000 **Out-of-Network** = N/A	**In Network** = $2,600/$5,200 **Out-of-Network** = $5,000/$10,000	**In Network** = $5,000/$10,000 **Out-of-Network** = $10,000/$20,000
Coinsurance (Chart shows employee responsibility)	**In Network** = $3,000/$6,000 **Out-of-Network** = N/A	**In Network** = $0/$0 **Out-of-Network** = $2,500/$5,000	**In Network** = $0/$0 **Out-of-Network** = $5,000/$10,000
Annual Out-of-Pocket Maximum(OOPM) (Calendar Year) Includes Copays, Deductible and Coinsurance	**In Network** = $3,500/$7,000 **Out-of-Network** = N/A	**In Network** = $2,600/$5,200 **Out-of-Network** = $7,500/$15,000	**In Network** = $5,000/$10,000 **Out-of-Network** = $15,000/$30,000
Allergy Testing	**In Network** = 100% * **Out-of-Network** = Not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Serums (Subject to Deductible and Coinsurance)	**In Network** = 100% * **Out-of-Network** = Not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Injections *If performed as part of Office Visit, $35 copay is charged and services are covered under copay.	**In Network** = 100% * **Out-of-Network** = Not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)

Medical Benefit Description	Self-Funded HMO Plan	HDHP Low	HDHP High
Ambulance	**In Network** = 100% **Out-of-Network** = 100% **Out of Network non-emergency ambulance is not covered**	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 100% (after deductible satisfied) **Out-of-Network non-emergency ambulance covered at 70% after deductible**	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 100% (after deductible satisfied) **Out-of-Network non-emergency ambulance covered at 70% after deductible**
Behavioral/Mental Health and Chemical Dependency - Inpatient (Includes ABA therapy)	**In Network** = 100% **Out-of-Network** = Not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Behavioral/Mental Health and Chemical Dependency - Outpatient (Includes ABA therapy)	**In Network** = 100% **Out-of-Network** = Not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Chiropractic Care	**In Network** = $35 copay **Out-of-Network** = Not covered Annual Maximum of 12 visits **Massage Therapy is not covered**	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied) Annual Maximum of 12 visits **Massage Therapy is not covered**	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied) Annual Maximum of 12 visits **Massage Therapy is not covered**

Medical Benefit Description	Self-Funded HMO Plan	HDHP Low	HDHP High
Diagnostic X-rays & Lab Services Diagnostic X-rays & Lab (per scan type per day)	**In Network** = Covered under applicable copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Advanced Imaging Services (MRI, PET, CT, MRA, CTA, SPECT) (Per scan type per day)	**In Network** = Covered under applicable copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Other	**In Network** = covered under applicable copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Durable Medical Equipment (Rental or purchase whichever is less costly)	**In Network** = 80%, no deductible applies **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Emergency Room Services *(Copay waived if admitted)	**In Network** = $100 copay **Out-of-Network** = $100 copay NOTE: Only true emergencies are covered; non-emergent care is not covered for Out-of-Network.	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 100% (after deductible satisfied) (non-emergent care covered at 70% after deductible)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 100% (after deductible satisfied) (non-emergent care covered at 70% after deductible)
Extended Care Facility **Acute and Sub-acute Rehabilitation Facility**	**In Network** = $35 copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Skilled Nursing Facility	**In Network** = $500 copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)

Medical Benefit Description	Self-Funded HMO Plan	HDHP Low	HDHP High
Home HealthCare	**In Network** = 80%, no deductible applies **Out-of-Network** = not covered)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Hospice Care	**In Network** = 100%, no deductible applies **Out-of-Network** = not covered)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Hospital Inpatient Hospital	**In Network** = $500 copay **Out-of-Network** = not covered)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Outpatient Hospital – Hospital Charges			
Surgery Procedures	**In Network** = $250 copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Cardiac Rehabilitation; Chemotherapy; Radiation Therapy; Dialysis Services	**In Network** = $50 copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Diagnostic Labs	**In Network** = 100%, no deductible **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Diagnostic X-rays	**In Network** = $35 copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)

Medical Benefit Description	Self-Funded HMO Plan	HDHP Low	HDHP High
Advanced Imaging Services (MRI, PET, CT, MRA, CTA, SPECT) (Per scan type per day)	**In Network** = $35 copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Other Services	**In Network** = $150 copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Physician Services – Physician Charges			
Primary Care Office Visit (Primary Care means a Family Practitioner, Internal Medicine, General Practitioner, Pediatrician, Nurse Practitioner, Physician's Assistant and Mental Health Provider.) *Copays do not apply toward the Deductible	**In Network** = $35 copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Specialist Office Visit	**In Network** = $35 copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Inpatient & Home Visits	**In Network** = 100%, no deductible applies **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Surgery Procedures – Inpatient & Outpatient	**In Network** = 100%, no deductible applies **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)

Medical Benefit Description	Self-Funded HMO Plan	HDHP Low	HDHP High
Pathology	**In Network** = covered under applicable copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Anesthesiology	**In Network** = covered under applicable copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Radiology	**In Network** = covered under applicable copay **Out-of-Network** = not covered	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100% (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Preventive Care Services (Deductible waived for in-Network services)	**In Network** = 100%, no deductible applies **Out-of-Network** = not covered	**In Network** = 100%, no deductible applies **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100%, no deductible applies **Out-of-Network** = 70% (after deductible satisfied)
Prosthetics	**In Network** = 80%, no deductible **Out-of-Network** = not covered	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Temporomandibular Joint Dysfunction	**In Network** = covered under applicable copay **Out-of-Network** = not covered	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)

Medical Benefit Description	Self-Funded HMO Plan	HDHP Low	HDHP High
Therapy Services **Physical /Occupational Therapy** (*Combined 40 visit limit per calendar year)	**In Network** = $35 copay **Out-of-Network** = not covered	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Speech (*40 visit limit per calendar year) * Visit limits for physical, occupational and speech therapy are not applicable to Pervasive Development Disorder Services.	**In Network** = $35 copay **Out-of-Network** = not covered	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Transplants	**In Network** = $500 copay **Out-of-Network** = not covered	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 70% (after deductible satisfied)
Urgent Care Center	**In Network** = $50 copay **Out-of-Network** = $50 copay	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 100% (after deductible satisfied)	**In Network** = 100%, (after deductible satisfied) **Out-of-Network** = 100% (after deductible satisfied)
Well Child Care & Immunizations (Deductible waived for in-Network services)	**In Network** = 100%, no deductible **Out-of-Network** = not covered	**In Network** = 100%, no deductible **Out-of-Network** = 70% (after deductible satisfied)	**In Network** = 100%, no deductible **Out-of-Network** = 70% (after deductible satisfied)

Deductible Information for HDHP Medical Plan

For Individual coverage, the Covered Person must meet the individual Deductible before Coinsurance is applied. For Family coverage, the remaining Deductible amount may be met by a combination of the family members at which time the Coinsurance is applied.

See Definitions section on Deductibles for additional information.

Medical Management:

IU Health Plans is designed to administer health insurance benefits for Covered Persons. To ensure that provided services are Clinically Appropriate, Medically Necessary, and cost effective, IU Health Plans Medical Management Department provides Utilization Management and Case Management Services.

IU Health Plans Medical Management Department performs Utilization Review upon request, by Primary Care Physicians (PCPs), specialty care Physicians, Behavioral Health clinicians, and a wide variety of other health practitioners. The scope of these services includes, but is not limited to, the following:

- Inpatient care
- Outpatient/Ambulatory care
- Surgical Services
- Office-based procedures
- Behavioral Health
- Skilled Nursing Facilities, Hospice, rehabilitation and home health services
- Home infusions and Durable Medical Equipment
- Referrals to out-of-Network Providers
- Care coordination

Urgent Review (which may be referred to as expedited) is a request for review of services, either before or during treatment, related to an Illness, disease, condition, Injury, or a disability, that with delay of review and subsequent determination, would seriously jeopardize the Covered Person's:

1. Life or health;
2. Ability to reach and maintain maximum function.
3. In the opinion of the treating Physician would subject the Covered Person to severe pain that cannot be adequately treated without the care and treatment that is the subject of the Appeal.

Timeframe for Decision and Notification: 72 hours
(*This requires submission of the clinical documentation necessary to complete the review)

Pre-service, concurrent, and post service are the case request types fulfilled by IU Health Medical Management.

Pre-service review (which may be referred to as Prior Authorization) is a request for services placed prior to care delivery. This process helps to ensure, before services or care is delivered, that the care and setting are Clinically Appropriate.

Timeframe for Decision and Notification: 15 days

Concurrent review ensures that services provided during ongoing care continue to meet guidelines supporting appropriateness for that level of care. Concurrent review processes also include discharge planning, in which a Nurse Reviewer evaluates a plan of care, screens for discharge planning needs, and collaborates with providers and Inpatient Care Managers to ensure seamless transitions of care.
Timeframe for Decision and Notification: 72 hours

Post service review (which may be referred to as retro-review or authorization) is a request for review, when services have already been rendered. IU Health Plans completes post service reviews, but recommends all services be reviewed prior to the date(s) of service, where feasible**.**
Timeframe for Submission: 30 Calendar Days from Date of Service
Timeframe for Decision and Notification: 30 Days

All unscheduled admissions or service requests that appear to be outside the scope of a member's coverage, or that are non-compliant with delivery system or Utilization Management guidelines, are referred to a Physician Reviewer for determination of benefit coverage. Reimbursement for medical and Behavioral Health services is based on confirmed clinical appropriateness and medical necessity, through the review processes described above.

Case Management

Case Management is a collaborative process that assists members with coordination of care needs, allowing them to reach their optimum level of wellness and self-management. It is characterized by advocacy, communication, and resource management that promotes cost effective interventions and outcomes. Selection of members for Case Management services may include, but are not limited to, the following:

- When coordination of multiple practitioners or multiple resources is required
- Physician or self-referrals for coordination of care
- When benefits are exhausted or when care may exceed the benefits available to the member
- When utilization patterns demonstrate a need for improved self-management through education of and assistance, providing information for evidence based practice around management of chronic or avoidable diseases
- Catastrophic Injury or Illness

Transition of Care Coverage

Transition of care coverage allows you to continue to receive treatment for Covered Services with a doctor and/or Facility that does not participate in an IU Health Plan's Network for a defined period of time until the safe transfer of care to an in-Network doctor and/or Facility can be arranged.

You may be eligible if you are:

a. A new enrollee in one of the MSD of Wayne Township Employee Medical Plans and you apply for Transition of Care at the time of enrollment or no later than 30 days after the Effective Date of your coverage or

b. An existing enrollee whose doctor and/or Facility is leaving the IU Health Plans Network

Examples of medical conditions that may qualify for Transition of Care include, but are not limited to:

- Pregnancy at the time of the Effective Date of coverage.
- Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
- Trauma.
- Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries still in the follow-up period (generally 6 to 8 weeks).
- Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions.
- Hospital Confinement on the Plan effective date.
- Behavioral Health conditions during active treatment.

The Transition of Care Request Form, including instructions for completion and submission for review, can be located at iuhealthplans.org.

Referrals/Tier 1 Level Benefits

Referrals are not needed to see a Provider for Covered Services. It is the Covered Person's responsibility to ensure services are performed by Network Providers to receive the highest level Tier 1 payment for Covered Services. If there is no Tier 1 Network Provider within a 60 mile radius of where the Covered Person lives or works (or within a 30 mile radius if services sought are expected to be provided at least biweekly or more often) or if there is no appointment available with a Network Provider within 30 days then Tier 1 benefits may be granted by the Plan upon prior request to the Plan by the Covered Person. Continuity of care requests for a new Covered Person to use Non-Network Providers at a Tier 1 benefit level shall only be granted in the event the Covered Person completes the Transition of Care Form and

meets Plan criteria and a high risk profile. The following list of services are routinely covered at Tier I, and do not require prospective review.

Non-Network anesthesiologist if the operating Facility is a Participating Provider.

- Radiologist or pathologist services for interpretation of x-rays and laboratory tests provided by a Non-Network Provider when the Facility participates in the Network.
- While confined to a Network Hospital, the Network Physician requests a consultation from the Non-Network Provider.
- Medically Necessary services, supplies and treatments not available through any Network Provider.
- Ambulance services.
- Non-Network assistant surgeon charges if the operating surgeon is a Network Provider.
- Urgent Care treatment.
- Emergency treatment at a Network Facility by a Non-Network Provider. If the Covered Person is admitted to the Hospital after such Emergency treatment, Covered Services shall be payable at the Network Provider level.

MSD of Wayne Township Employee Benefits Plan -- Coverage Clarifications

The following section provides benefit coverage clarifications for MSD of Wayne Township Employee Benefits Plan, further explaining the previous Benefits Schedule Summary chart. Behavioral Health includes all services for Mental Health and Chemical Dependency. Refer to Section Seven: Definition of Terms for additional information about how services are defined. Refer to the Benefits Schedule Summary for coverage levels.

When a Covered Person receives services, the Deductible is subtracted from the Covered Charge and the benefits will then be calculated from the remaining amount, based on the applicable Copayment, Coinsurance, maximums and benefits limits. Copays are paid at time of service.

Allergy

The Plan pays for allergy testing that consists of percutaneous, intracutaneus and patch tests, and allergy injections.

Allergy testing is subject to the Specialty office visit Copayment or the Deductible and Coinsurance depending on the Covered Person's medical Plan and choice of where care is received.

Injections and serum are subject to Deductible and Coinsurance.

Ambulance Services

Ambulance services must be provided by a licensed air or ground ambulance which is staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals and equipped to transport the sick or injured.

Covered Services shall include:

1. Ambulance service for air or ground transportation for the Covered Person from the place of Injury or serious medical incident to the nearest Hospital where treatment can be given.
2. Non-emergent ambulance service is covered only to transport the Covered Person to or from a Hospital or between Hospitals or Extended Care Facilities for required treatment. Non-emergent ambulance transport must receive Prior Authorization from Medical Management. Service will be covered if ambulance transport is determined to be Medically Necessary by Medical Management. Such transportation is covered only from the initial Hospital to the nearest Hospital qualified to render the special treatment. Ambulance service between Hospitals is also covered if the Covered Person is required by the Plan Administrator to move from a Non-Network Provider to a Network Provider.
3. Ambulance service when a Covered Person is ordered by an Employer, school, fire or public safety official to be transported by ambulance and the Covered Person is not in a position to refuse.

Ambulance services are not Covered Services if they are:

1. To a Physician's office or clinic;
2. To a morgue or funeral home.
3. An Ambulance service which is only for the convenience of the Covered Person, family or Physician or is not Medically Necessary.

Autism

Autism Spectrum Disorder (ASD) and Pervasive Developmental Delay (PDD) coverage will be in parity and consistent with coverage for other medical and psychological conditions, such as for visit limits.

Services and treatments must be "established" treatments as defined by the National Standards Project. Established treatments will be covered benefits and are defined by the National Standards Project as treatments for which scientific evidence has shown the intervention produces beneficial effects, although universal improvements cannot be expected to occur in all individuals.

ABA Therapy for Autism – Applied Behavior Analysis therapy requires Precertification and involves the modification of situational events that typically precede the occurrence of a target behavior. These alterations are made to increase the likelihood of success or reduce the likelihood of problems occurring.

Treatment includes but is not restricted to: behavior chain interruption (for increasing behaviors); behavioral momentum; choice; contriving motivational operations; cueing and prompting/prompt fading procedures; environmental enrichment; environmental modification of task demands, social comments, adult presence, intertribal interval, seating, familiarity with stimuli; errorless learning; errorless compliance; habit reversal; incorporating echolalia, special interests, thematic activities, or ritualistic/obsessional activities into tasks; maintenance interspersal; noncontingent reinforcement; priming; stimulus variation; and time delay.

ABA therapy performed in the home or in an Outpatient setting is subject to the Deductible and Coinsurance.

Behavioral/ Mental Health and Chemical Dependency

Inpatient or Partial Confinement is subject to Precertification. The Plan covers services, supplies and treatment during Confinement or Partial Confinement in a Hospital or Treatment Center related to the treatment of Behavioral/Mental Health and Chemical Dependency. Coverage for Inpatient and Outpatient treatment of Behavioral/Mental Health and Chemical Dependency conditions are provided to the same extent and degree as for the treatment of a physical Illness.

Outpatient visits are Covered Services for short-term evaluation or crisis intervention Behavioral/Mental Health and Chemical Dependency. Physician services for Outpatient visits are paid the same as the medical office visit. Prior Authorization for services is not required.

Chiropractic Care

Covered Services include an initial or follow up consultation, spinal manipulation, x-rays, physical therapy and other modalities that a Chiropractor is licensed to perform. Benefits are subject to the maximums shown in the Schedule of Benefits. All services, whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward the Maximum Benefits for Chiropractic Care.

Coinsurance

The Plan pays a specified percentage for Covered Services at the Customary and Reasonable Amount for Non-Network Providers, or the percentage of the Negotiated Rate for Network Providers as specified in the Schedule of Benefits in this section.

The Covered Person is responsible for the difference between the percentage the Plan paid and 100 percent of the Negotiated Rate for Network Providers. For Non-Network Providers, the Covered Person is responsible for the difference between the percentage the Plan pays of the Customary and Reasonable Amount and 100 percent of the billed amount. The Covered Person's portion of the Coinsurance represents the out-of-pocket limit.

Copayments

The Copayment is the amount the Covered Person is expected to pay for certain services, supplies or treatment at the time of service. Copayments are not applied to the calendar year Deductibles.

Cosmetic Surgery

Specified Cosmetic/reconstructive Surgeries are subject to Precertification. Cosmetic Surgery shall be a Covered Expense provided:

1. A Covered Person receives an Injury as a result of an accident and as a result requires Surgery. Cosmetic Surgery and treatment must be for the purpose of restoring the Covered Person to his or her normal function immediately prior to the accident.
2. It is required to correct a congenital anomaly, for example, a birth defect for a child.

Mastectomy

Covered Services shall include the following:

1. Medically Necessary mastectomy, including complications from a mastectomy, including lymphedemas.
2. Reconstructive breast Surgery necessary because of a mastectomy.
3. Reconstructive breast Surgery on the non-diseased breast to make it equal in size with the diseased breast following reconstructive Surgery on the diseased breast.
4. External breast prosthesis and permanent internal breast prosthesis.

Deductibles

Individual Deductible
The individual Deductible is the specified dollar amount of Covered Charges a Covered Person must have Incurred during the calendar year before the Plan pays applicable benefits and the individual will be considered to have met the Deductible for the remainder of the calendar year. The individual Deductible amount is shown on the Schedule of Benefits. Benefits are paid according to the date the claim is received by the Plan, not the service date.
Individual Deductible applies to coverage for one person. In the case of Employee Only coverage, the Employee must satisfy the Deductible before Coinsurance and contributions to the Out-of-Pocket Maximum begin.

For Family coverage on the Self-Funded HMO Plan, the deductible is "**embedded**" meaning when any one individual family member reaches the individual deductible limit, the benefit plan coverage takes effect for that member only. The remaining deductible amount may be met by a combination of the family members at which time the benefit plan coverage takes effect for the family. Deductibles accrue toward the 100% maximum out-of-pocket payment.

For Family coverage on the HDHP Low and High Deductible Plan, the deductible is "**embedded**" meaning when any one individual family member reaches the individual deductible limit, the

benefit plan coverage takes effect for that member only. The remaining deductible amount may be met by a combination of the family members at which time the benefit plan coverage takes effect for the family. Deductibles accrue toward the 100% maximum out-of-pocket payment.

Family Deductible
The family Deductible means the specified dollar amount of Covered Charges that must be Incurred by family Covered Persons before the Plan pays applicable benefits and family Covered Persons will be considered to have met the Deductible for the remainder of the calendar year. The family Deductible amount is shown on the Schedule of Benefits. Benefits are paid according to the date the claim is received by the Plan, not the service date.
In each calendar year, if Covered Persons of a family incur Covered Charges that are subject to the Deductible, equal to or greater than the dollar amount of the family Deductible shown on the Schedule of Benefits, the family Deductible will be considered satisfied for all family Covered Persons for that calendar year. Any number of family Covered Persons' Covered Services may contribute to satisfying the family Deductible amount.

Dental Services

Dental services referenced in this section are for services under the Plan. Covered Services shall include the initial repair of the jaw, sound natural teeth, mouth or face provided it is the result of an Injury. Treatment must be provided within 12 months after the Injury or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental-related Injury, there may be several years between the accident and the final repair. Damage to the teeth as a result of chewing or biting shall not be considered an Injury under this benefit. Covered Services for accidental dental work include, but are not limited to:

1. Oral examinations;
2. X-rays;
3. Tests and laboratory examinations;
4. Restorations;
5. Prosthetic services;
6. Oral Surgery;
7. Mandibular/maxillary reconstruction;
8. Anesthesia.

Diagnostic Services and Supplies

Covered Services shall include, but are not limited to, the following:

1. X-ray and other radiology services, including mammograms for any Covered Person diagnosed with breast disease; Coverage for radiology services requires Precertification for anything on the Prior Authorization list. The list of services requiring Precertification can change at any time.
2. Laboratory and pathology services;
3. Cardiographic, encephalographic, and radioisotope tests;
4. Ultrasound services;

5. Allergy tests;
6. Electrocardiograms (EKG);
7. Electromyograms (EMG) (surface EMGs are not covered);
8. Echocardiograms;
9. Bone density studies;
10. Advanced Imaging:
    a. CAT Scans (CT),
    b. Positron Emission Tomography (PET Scans),
    c. Single Photon Emission Computed Tomography (SPECT Scans)
    d. Magnetic Resonance Angiography (MRA),
    e. Computed Tomography Angiography (CTA),
    f. Magnetic Resonance Imaging (MRI).

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

Coverage for some radiology services requires Precertification. The list of services requiring Precertification can be found at iuhealthplans.org and is subject to change at any time.

Exclusions – Unless otherwise provided, services not covered include:

1. Eye refractions
2. Examinations for the fitting of eyeglasses, or contact lenses
3. Dental examinations
4. Premarital examinations
5. Research studies, screening examinations, Physician examinations or check-ups other than those described under well-child care and well-person care.

Durable Medical Equipment

Rental or purchase, whichever is less costly, of necessary Durable Medical Equipment, which is prescribed by a Physician and required for therapeutic use by the Covered Person, shall be a Covered Service. Equipment ordered prior to the Covered Person's Effective Date of coverage is not covered, even if delivered after the Effective Date of coverage. Repair or replacement of purchased Durable Medical Equipment, which is Medically Necessary due to normal use or physiological change in the patient's condition, will be considered a Covered Service. Coverage for Durable Medical Equipment requires Precertification for any services on the Prior Authorization list and all services over $500. The list of services requiring Precertification can change at any time.

Equipment containing features of an anesthetic nature or features of a medical nature which are not required by the Covered Person's condition, or where there exists a reasonably feasible and Clinically Appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the customary and reasonable charge for the equipment which meets the Covered Person's medical needs.

Covered Service includes: the rental, initial purchase, repair and replacement of equipment that is appropriate for home use and is used to treat Illness or Injury.

Exclusions include: Routine maintenance. Covered Charges for deluxe items are limited to the cost of standard items. Covered Charges for rental are limited to the purchase price of the equipment.

Prostheses

Covered Services include initial purchase, fitting, needed adjustment, repair and replacement of fitted prosthetic devices (artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes) and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues, or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetics require Prior Authorization for any services over $500. Covered Services shall include, but are not limited to:

1. Aids and supports for defective parts of the body, including but not limited to internal heart valves, internal pacemakers, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates and vitallium heads for joint reconstruction;
2. Left Ventricular Artificial Devices (LVAD) – when used as a bridge to a heart transplant or as a lifesaving/prolonging treatment;
3. Breast prosthesis, whether internal or external, following a mastectomy and two surgical bras per calendar year;
4. Minor devices for repair such as screws, nails, sutures and wire mesh;
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses following lens implantation are also covered. If cataract Surgery is performed, lenses are usually inserted during the same operative session;
7. Artificial gut systems (parental devices necessary for long-term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered);
8. Cochlear implants;
9. Electronic speech aids in post laryngectomy or permanently inoperative situations;
10. "Space shoes" when used as a substitute device when all or a substantial portion of the forefoot is absent;
11. Wigs (the first one following cancer treatment, one per calendar year).

No benefits are payable under this provision of the Plan for: dentures replacing teeth or structures directly supporting teeth; dental appliances; non-rigid appliances such as elastic stockings, garter belts, arch supports and corsets; hairpieces for male pattern baldness (alopecia); wigs, except as specified.

Orthotics

Covered Services include the initial purchase, fitting and repair and replacement of a custom-made orthotic device or appliance (a rigid or semi-rigid supportive device used to support, align, prevent or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part). The cost of casting, molding, fittings and adjustments are also included. Orthotics require Prior Authorization for services more than $500. Covered orthotic devices include, but are not limited to:

1. Cervical collars;
2. Ankle foot orthotics;
3. Corsets (back and special surgical);
4. Splints (extremities);
5. Trusses and supports;
6. Slings;
7. Wristlets;
8. Built-up shoe;
9. Custom-made shoe inserts.

Medically Necessary replacement of orthotic devices or appliance will be covered, but limited to once per calendar year. However, additional replacements will be covered for Covered Persons under age 18 if required due to rapid growth or for any Covered Person when the orthotic is damaged or cannot be repaired.

No benefits are payable under this provision of the Plan for: orthopedic shoes; foot support devices, such as arch supports or corrective shoes, unless they are an integral part of a leg brace; standard elastic stockings, garter belts and other supplies not specially made and fitted.

Emergency Services/Emergency Room

A life-threatening Emergency is a condition or symptom that arises suddenly and unexpectedly. It has acute symptoms of such severity that without immediate medical attention it could be reasonably expected by a prudent layperson (person with an average knowledge of health and medicine) to:

- Permanently jeopardize the individual's health;
- Result in serious medical consequences;
- Cause serious impairment of bodily function; or
- Result in serious harm or permanent dysfunction of any bodily organ or part.

If a life-threatening Emergency occurs, call 911 or seek Medical Care immediately. Remember to advise your primary Physician for coordination of follow up care. Emergency Copayments apply for Traditional Plan members unless admitted.

See Urgent Care for information about receiving services in an Urgent Care situation.

Extended Care/Skilled Nursing

Coverage for an Extended Care Facility or skilled nursing stay is subject to Precertification. Custodial Care is not covered. Covered Charges shall include:

1. Room and Board (including regular daily services, supplies and treatments furnished by the Extended Care Facility) limited to the Facility's average semiprivate room rate; and
2. Other services, supplies and treatment ordered by a Physician and furnished by the Extended Care Facility for Inpatient Medical Care.

Hearing Aids

Covered services include audiometric testing, when performed to determine the need for a hearing aid. Cochlear implants are covered, if medically necessary. Hearing aids are covered, subject to annual limitations of one hearing per ear, $1,500 per hearing aid. Hearing aids are limited to two total hearing aids per every three years.

Home HealthCare

Home Healthcare is subject to Precertification. Home Healthcare enables the Covered Person to receive treatment in his home for an Illness or Injury instead of being confined in a Hospital or Extended Care Facility. Services must be provided on a Part-Time visiting basis according to a Plan of treatment. The Covered Person must have been referred to a Home Healthcare Agency by a Physician, and the Provider must not be a Covered Person of your immediate family.

Covered Services shall include, but are not limited to:

1. Intermittent skilled nursing care by a registered Nurse or Licensed Practical Nurse;
2. Diagnostic services;
3. Medical/social services;
4. Nutritional guidance;
5. Home Health Aide Services;
6. Therapy services;
7. Medical/surgical supplies;
8. Durable Medical Equipment;
9. Prescription Drugs if provided and billed by a Home Healthcare Agency;
10. Private duty nursing services.

Home Infusion Therapy

Covered Services will include charges for home infusion therapy, including a combination of nursing, Durable Medical Equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy.

Hospice Care

Hospice care is subject to Precertification. Hospice care is a healthcare program that provides a coordinated set of services at home, in Outpatient settings, or in Facility settings for a Covered Person suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the Covered Person's attending Physician certifies that:

1. The Covered Person is terminally ill, and
2. The Covered Person has a life expectancy of six months or less.

Covered Services shall include:

1. Skilled nursing services by a registered Nurse or licensed practical Nurse;
2. Diagnostic services;
3. Physical, speech and inhalations therapies;
4. Medical supplies, equipment and appliances;
5. Counseling services (except bereavement counseling);
6. Inpatient stay at a Hospice;
7. Prescription Drugs obtained from the Hospice.

Charges Incurred during periods of remission are not eligible under this provision. Any Covered Charges paid under Hospice benefits will not be considered a Covered Charge under any other provision of this Plan.

Hospital/Ambulatory Surgical Facility – Inpatient & Outpatient

Inpatient Hospital admissions and specified Outpatient procedures and services are subject to obtaining Precertification from the IU Health Medical Management Department. Obtaining Precertification is the responsibility of both the Physician and the Plan Covered Person. (Refer to the section on Medical Management for additional Precertification information.) If a patient is transferred from one Hospital to another on the same day, the Copay for the second admission is waived. Refer to the Schedule of Benefits for benefits coverage.

Covered Services shall include:

1. Room and Board for treatment in a Hospital, including intensive care units, cardiac care units and similar necessary accommodations. Covered Services for Room and Board shall be limited to the Hospital's Semi-Private rate. Covered Services for intensive care or cardiac care units shall be the Customary and Reasonable Amount or Negotiated Rate, as applicable. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the Covered Person.
2. Miscellaneous Hospital services, supplies, and treatments including, but not limited to:
    a. Admission fees, and other fees assessed by the Hospital for rendering Medically Necessary services, supplies, and treatments;
    b. Use of operating, treatment or delivery rooms;
    c. Anesthesia, anesthesia supplies and its administration by an employee of the Hospital;

d. Medical and surgical dressings and supplies, casts and splints;
e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
f. Drugs and medicines (except drugs not used or consumed in the Hospital);
g. X-ray and diagnostic laboratory procedures and services;
h. Oxygen and other gas therapy and the administration thereof;
i. Therapy services.

3. Services, supplies, and treatments described above furnished in an Outpatient setting by an Ambulatory Surgical Facility, including lithotripsy treatment.
4. Charges for preadmission testing (x-rays and lab tests) performed within seven days prior to a Hospital admission which are related to the condition which is necessitating the Hospital stay. Such tests shall be payable even if they result in additional medical treatment prior to admission or if they show that the Hospital stay is not necessary. Such tests shall not be payable if the same tests are performed again after the Covered Person has been admitted.

Maximum Benefit

The Schedule of Benefits contains Maximum Benefit limitations for specified conditions, including, but not limited to: physical, occupational, and speech therapy, and Chiropractic Care.

Medical Services

Covered Services are subject to applicable Plan provisions, including, but not limited to: Deductible, Copayment, Coinsurance, Maximum Benefit and limitations. Services, supplies and treatment must not exceed the Customary and Reasonable Amount or Negotiated Rate and must be ordered by a Physician or Provider, and be Medically Necessary for the care of a Covered Person.

Out-of-Pocket Maximum Per Calendar Year

After the individual or family has Incurred an amount equal to the Out-of-Pocket Maximum listed on the Benefits Table Summary (after satisfaction of applicable Deductibles), the Plan will begin to pay 100 percent for Covered Services for the remainder of the calendar year or until the Maximum Benefit has been reached (where applicable).

Out-of-Pocket Maximum – The following items do not apply toward satisfying the calendar year Out-of-Pocket Maximum:

1. Expenses for services, supplies and treatments not covered by this Plan, to include charges in excess of the Customary and Reasonable Amount or Negotiated Rate, as applicable.
2. Dental services are not covered; dental services are only available under separately selected dental options (see the “Dental Insurance” section).
3. Expense Incurred as a result of failure to obtain Precertification.

Physician Services

Physician Covered Services shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, Inpatient visits, and home visits.
2. Surgical treatment. Separate payment will not be made for Inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   For related operations or procedures performed through the same incision or in the same operative field, covered expenses shall include the surgical allowance for the highest paying procedure, plus 50 percent of the surgical allowance for second highest paying procedure and 25 percent of the surgical allowance for each additional procedure.

   When two or more unrelated operations or procedures are performed at the same operative session, Covered Charges shall include the surgical allowance for each procedure.
3. Surgical assistance provided by a Physician if it is determined that the condition of the Covered Person or the type of surgical procedure requires such assistance. Covered Charges for the services of an assistant surgeon shall be limited to 20 percent of the surgeon's billed charges or the contracted amount whichever is less.
4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.
5. Consultations requested by the attending Physician during a Hospital stay. Consultations do not include staff consultations, which are required by a Hospital's rules and regulations.
6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.
8. Allergy testing consisting of percutaneous, intracutaneus and patch tests and allergy injections.

Inpatient Medical Visits, Consultations

One visit per Physician per day per diagnosis is allowed, unless a surgeon's visits are included with the Surgery fee and are covered under the Plan.

Assistant Surgeon

A Covered Service if the surgeon needs the assistance of a second surgeon during major Surgery. Includes surgical assistance provided by a Physician if it is determined that the condition of the Covered Person or the type of surgical procedure requires such assistance. Covered Charges for the services of an assistant surgeon shall be limited to 20 percent of the surgeon's allowable amount.

Anesthesia

General and local anesthesia (other than local infiltration anesthesia and anesthesia supplies) when it is Medically Necessary. The service must be performed by a Provider other than the surgeon or assistant surgeon.

Second Surgical Opinion

Benefits for a second surgical opinion will be payable if an elective surgical procedure (non-Emergency Surgery) is recommended by the Physician. The Physician providing the second opinion regarding the Medical Necessity of such Surgery must be a board-certified Specialist in the treatment of the Covered Person's Illness or Injury and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The Plan will consider payment for a third opinion the same as a second surgical opinion.

Podiatry Services

Covered Services include the treatment of fractures and dislocations of bones of the foot and surgical treatments (incision and drainage, removal of lesions, removal of infected toenails or nail roots). Covered Services for nonsurgical care includes: metabolic (diabetics) or peripheral-vascular Illness. The nonsurgical care for Covered Persons with diabetes, peripheral neuropathy or peripheral vascular disease includes nonsurgical care of the toenails, treatment of corns and calluses and foot injections.

Pregnancy

Covered Services for pregnancy or Complications of Pregnancy shall be provided for a Covered Person, a covered spouse of a Covered Person, or Dependent children.

Pregnant and postpartum individuals will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment and supplies.

100 percent coverage is provided for breast pumps and supplies obtained through IU Health Homecare Expressions. Rentals are not covered. Precertification is required for Hospital grade breast pumps.

For further details contact IU Health Plans Member Services at 800.873.2022 or 317.816.5170 or visit the IU Health Plans website: iuhealthplans.org.

In the event of early discharge from a Hospital or Birthing Center following delivery, the Plan will cover at-home post-delivery care visits at the parent's home by a Physician or Nurse when performed no later than 48 hours following discharge from the Hospital. Covered Services include, but are not limited to:

1. Parent education;
2. Physical assessment;
3. Assessment of the home support system;
4. Assistance and training in breast or bottle feeding;
5. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

   At the patient's discretion, this visit may occur at a Physician's office.

Note: You or your Physician must call the Plan within one working day after your maternity admission. Additional days must be certified/authorized if a newborn remains in the Hospital after the mother's discharge. See the Medical Management section for more information about authorizing/certifying Inpatient admissions.

Note: You must add your newborn to your coverage within 30 days of birth to be enrolled in the Plan. If this is not accomplished within the first 30 days, the newborn will not be able to be added until the next annual open enrollment period. Payment of claims within the first 30 days does not mean your newborn has been added. Please contact Human Resources to obtain enrollment information.

Nurse midwives are considered Network Providers. Refer to the Provider Directory to ensure they are Participating in the Network.

The Plan shall cover services, supplies and treatment of an abortion including elective abortions if the pregnancy is a result of rape or incest or if continuing the pregnancy is life-threatening to the mother. Complications will be covered if the abortion is a covered procedure.

Birthing Center

Covered Services shall include services, supplies and treatments provided at a Birthing Center when the Physician in charge is acting within the scope of his/her license and the Birthing Center meets all legal requirements. Services of a Network midwife acting within the scope of the license or registration are Covered Services provided that the state in which such service is performed has legally recognized midwife delivery.

Newborns' and Mothers' Health Protection Act

Under the Newborns' Act, the health plan may not restrict benefits for a hospital stay in connection with childbirth to less than 48-hours (96-hours in case of a cesarean section), unless the attending provider (in consultation with the mother) decides to discharge earlier. Plans may not require providers to obtain authorization from the plan for prescribing the stay. In addition, plans may not deny a stay within the 48-hour (or 96-hour) period because the Plan's utilization reviewer does not think such a stay is medically necessary. The plan must eliminate this preauthorization requirement with respect to hospital stays in connection with childbirth for the first 48-hours (or 96-hours in the case of a cesarean section). The Plan may impose such an authorization requirement for hospital stays beyond this period. In addition, the Plan may impose a requirement on the mother to give notice of a pregnancy in order to obtain a certain

level of cost-sharing or to use certain medical facilities. However, the type of preauthorization required by this Plan (within 48- or 96-hour period and based on medical necessity) must be eliminated.

Preventive Care

Expanded preventive care screenings and coverage is available without Covered Person cost-sharing when provided by a Network Provider. For a complete list of routine preventive screenings and exams for adults and children, please see the listing in Appendix A, or you may access the Preventive Services link on the Plan website at www.iuhealthplans.org

Covered Services include Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, sports physicals and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/preventive-care-benefits/ for more details.

Important Note: The Preventive Care services identified through these links are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered.

Routine preventive screenings that result in abnormal findings may have portions of the service that are considered diagnostic procedures. Applicable Deductibles and Coinsurance will apply to the diagnostic portions of the service. However, services (such as pathology and polyp removal) associated with polyps found during a routine age appropriate colonoscopy will be covered with no cost sharing.

Special Equipment and Supplies

Covered Services shall include Medically Necessary special equipment and supplies including, but not limited to: casts; splints; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; syringes and needles; allergy serums; crutches; oxygen and the administration thereof; soft lenses or sclera shells intended for use in the treatment of Illness or Injury of the eye; Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to Depo-Provera, surgical dressings and other medical supplies ordered by a Provider in conjunction with medical treatment, but not common first aid supplies.

Sterilization

Covered Services shall include elective sterilization procedures for the Covered Person. Reversal of sterilization is not a Covered Service.

Temporomandibular Joint Dysfunction (TMJ)

Diagnostic, surgical and nonsurgical treatment of temporomandibular joint (TMJ) dysfunction, including orthotic appliances. An orthotic appliance for TMJ is a similar to a mouth guard that pushes the joint into a more proper and less painful position. Orthodontia such as braces is not a Covered Service.

Therapy Services

Therapy services must be ordered by a Physician to aid restoration of normal function lost due to Illness or Injury, for congenital anomaly, or for prevention of continued deterioration of function.

Covered Services shall include:

1. Services of a Physical Therapist for physical therapy, including treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is provided to relieve pain, restore function and to prevent disability following Illness, Injury or loss of a body part.
2. Services of a Provider licensed in occupational therapy for treatment by means of constructive activities designed and adapted to promote the restoration of a person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational or vocational therapies (e.g., hobbies, arts and crafts).
3. Services of a Network Provider licensed in speech therapy for speech therapy for correction of speech impairment.
4. Therapy Services are subject to annual visit limitations. Physical, Occupational, and Speech Therapy are limited to 40 visits annually, for each therapy. Chiropractor visits are limited to 12 visits annually. Massage therapy is not a covered benefit.

Other Therapy Services – Covered Services shall include:

1. Radiation therapy for the treatment of disease by x-ray, radium or radioactive isotopes.
2. Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.
3. Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases or anesthetics by inhalation.
4. Dialysis treatments of an acute or chronic kidney ailment (renal failure or insufficiency), which may include the supportive use of an artificial kidney machine. This includes hemodialysis and peritoneal dialysis.
5. Cardiac rehabilitation to restore an individual's functional status after a cardiac event. Home programs, ongoing conditioning and maintenance are not covered.
    a. Note: Prior to receiving cardiac rehabilitation services, contact the Plan's Member Services for verification of coverage.
6. Orthoptic Pleoptic Therapy **–** The treatment of an abnormal condition, such as strabismus, by visual training exercises.
    a. Note: Prior to receiving treatment, contact the Plan's Member Services for verification of coverage.

7. Respiratory/Inhalation Therapy – The introduction of dry or moist gases into the lungs for treatment purposes.

Transplants -- Organ and Tissue

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered Covered Services subject to the following conditions:

1. When the recipient is covered under this Plan, the Plan will pay the recipient's Covered Charges related to the transplant.
2. When the donor is covered under this Plan, the Plan will pay the donor's Covered Services related to the transplant.
3. Expenses Incurred by the donor who is not covered under this Plan according to eligibility requirements will be Covered Charges to the extent that such expenses are covered by the plan.
4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a Covered Service under this Plan.
5. If the transplant is performed more than 75 miles from the patient's residence, Covered Charges shall include charges for transportation and lodging for the covered recipient and one other person (two other persons if the recipient is an eligible Dependent child) to accompany the recipient to and from a Facility and for lodging at or near the Facility where the recipient is confined, with prior approval from the Plan.
    a. Reasonable and necessary lodging and meal expenses are covered up to $200 per day. There is a $10,000 limit for all transportation, lodging and meals per transplant procedure.) Benefits for organ or tissue transplants are payable for Covered Charges Incurred during a transplant benefit period which begins one day before the transplant and ends 364 days after the date of the transplant. After the end of the transplant period, any immunosuppressant drugs shall be payable under the Prescription Drug benefit.
6. Private duty nursing by a registered Nurse or a licensed practical Nurse when recommended by a Physician. (A Nurse who is a family Covered Person of the recipient or who normally lives in the recipient's home is not covered.) Inpatient private duty nursing is covered only if the Hospital's regular staff cannot provide the care needed due to the recipient's condition. (There is a $10,000 limit on all private duty nursing per transplant procedure.)

If a Covered Person's transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Covered transplant procedures include:

- Bone marrow (autologous and allogenic)
- Heart
- Heart/lung

- Intestine
- Lung
- Liver
- Multivisceral
- Pancreas
- Kidney
- Kidney/pancreas
- Cornea.

Transplant Covered Services include:

1. Inpatient and Outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery;
3. Procurement of an organ or tissue;
4. Reasonable and necessary lodging and meal expenses Incurred by the recipient's companion(s) are covered up to $200 per day. (There is a $10,000 limit for all transportation, lodging and meals per transplant procedure.)
5. Private duty nursing by a registered Nurse or a licensed practical Nurse when recommended by a Physician. (A Nurse who is a family Covered Person of the recipient or who normally lives in the recipient's home is not covered.) Inpatient private duty nursing is covered only if the Hospital's regular staff cannot provide the care needed due to the recipient's condition. (There is a $10,000 limit on all private duty nursing per transplant procedure.)
6. Rental of Durable Medical Equipment for use outside the Hospital, limited to the purchase price of the same equipment.
7. Prescription Drugs, including immunosuppressive drugs; oxygen and diagnostic services. After the end of the transplant period (364 days after the date of the transplant), any immunosuppressive drugs shall be payable under the Prescription Drug benefit.
8. Speech therapy, audiotherapy, visual therapy, occupational therapy, physical therapy and chemotherapy. (Speech therapy for voice training or to correct a lisp is not covered.)
9. Services and supplies for high-dose chemotherapy when provided as part of a treatment Plan that includes bone marrow transplantation. (Coverage for high-dose chemotherapy is provided only if the Covered Person is in an FDA-approved Phase III or IV clinical trial and no alternative conventional treatment can be expected to result in an equal or better benefit or outcome.)
10. Surgical dressing and supplies.
11. Home healthcare by healthcare personnel, as recommended by a Physician to provide skilled care to the recipient.

Multiple Transplant Procedures

If a recipient requires more than one covered transplant procedure, the transplant services described in the Organ and Tissue Transplants section will be treated as follows:

- If each transplant is due to related causes, each is considered as a separate benefit if the transplants are separated by at least 90 days. (If the transplants are due to related

causes and they are not separated by at least 90 days, then they are considered as one benefit and the limits under Organ and Tissue Transplants Section shall apply to the transplants.)

For questions about the Organ and Tissue Transplants or Multiple Transplant Procedures, contact the Plan's Member Services, 800.873.2022 or 317.816.5170.

Urgent Care

An urgent medical problem is an unforeseen Illness or Injury that is not life-threatening but does require prompt evaluation.

If an urgent medical problem occurs and Medical Care cannot be delayed, contact your Primary Care Physician or proceed to any urgent or immediate care Facility for treatment. After receiving care, advise your Primary Care Physician for further follow up care. Familiarize yourself with Urgent Care and immediate care facilities near your home and work so you're prepared when the need arises.

Well-Child Care

Well-child Covered Services include:

1. The initial routine newborn examination following delivery when performed in a Hospital by a Physician other than the delivering Physician;
2. Subsequent routine visits by a Physician to the newborn, until the newborn is released from the Hospital; and

Immunizations, TB tine tests and urinalysis, according to preventive guidelines, For a list of preventive services access the preventive services link on the IU Health Plans website at myiuhealthplan.com. Exclusions – Immunizations and office visits for school, camp, travel and sports are not covered.

Well Newborn Care

The Plan shall cover well newborn care as part of the mother's Covered Services during the delivery stay. Such care shall include, but is not limited to:

1. Physician services;
2. Hospital services;
3. Circumcision.

Well-Person Care

Covered Services include routine services, including immunizations and physical examinations for Covered Persons age eight and older.

Exclusions – Immunizations and physical examinations required for sports, school, camp, employment, and travel are not covered.

MSD of Wayne Township Employee Benefits Plan – Exclusions

Coverage is Not Provided for the Following Services and Supplies

The Plan will not provide coverage for any of the items listed in this section, regardless of Medical Necessity or recommendation of a Physician or Professional Provider.

General Exclusions

1. Charges for any services, supplies or treatment not specifically provided in this Summary Plan Description.
2. Charges for services, supplies and treatment, which is not Medically Necessary for the treatment of Illness or Injury, or which are not recommended and approved by the attending Physician, except as specifically stated in this Summary Plan Description, or to the extent that the charges exceed the Customary and Reasonable Amount or exceed the Negotiated Rate as applicable.
3. Any treatment not recommended or approved by a Physician or medical Provider.
4. Any services, supplies or treatment for which the Covered Person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
5. Services provided by a Covered Person of your immediate family, Close Relative or who resides in the same household as the Covered Person.
6. Expenses paid by another Plan.
7. Services received under the following circumstances:
    a. Physician examinations or services required by an insurance company to obtain insurance;
    b. Physical examinations or services required by a governmental agency such as the Federal Aviation Administration, Department of Transportation, and Immigration and Naturalization Services;
    c. Physical examinations or services required by an Employer in order to begin or continue working, unless Clinically Appropriate;
    d. Premarital examinations and associated required testing; or
    e. Physical examinations or screening test for professional school or private school.
8. Services, supplies or treatment provided by a Hospital or institution maintained by the U.S. Government or any agency thereof or any government outside the U.S., or charges for services, treatment or supplies furnished by the U.S, government or any agency thereof or any government outside the U.S., unless payment is legally required.
9. Treatment for any Illness or Injury caused by war and acts of war – whether the war is declared or undeclared – participation in a riot, civil disobedience or insurrection or similar events whether civil or international or any substantial armed conflict between organized forces of a military nature.
10. Treatment for Illness or Injury contracted while in any branch of the armed forces or military service unless payment is legally required.
11. Treatment for Illness or Injury Incurred while committing or attempting to commit a felony, or other criminal activity. Claims shall be denied if the Plan Administrator has

reason to believe, based on objective evidence such as police reports or medical records, that a criminal act or felony was committed.

12. Expenses reimbursed for which you are entitled to reimbursement through any public program.
13. Services or expenses that are prohibited by law in the area in which you reside at the time the expense is Incurred.
14. Charges for court-ordered treatment that is not Medically Necessary.
15. Charges for services or supplies in connection with an occupational Injury covered by workers' compensation or in conjunction with occupational disease law.
16. Charges for services, supplies, or treatments, which are primarily educational in nature, except as provided in this Summary Plan Description; charges for services for educational, vocational testing, or training and work-hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.
17. Services of any kind for developmental, diversional, or recreational purposes.
18. Charges associated with telephone consultations, missed appointments, completion of claim forms, or copies of medical records.
19. Expenses associated with custodial, Domiciliary, convalescent or intermediate care.
20. Charges for private-duty nursing, except as provided through the home healthcare benefit.
21. Charges for services Incurred due to complications of leaving the medical Facility Against Medical Advice.
22. Charges for environmental control or structural change including a Hospital, home, property or equipment, or Physician charges connected with prescribing an environmental change.
23. Charges for Experimental or Investigational procedures, drugs, devices, or medical treatments.
24. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a Physician, such as television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-Hospital adjustable beds, exercise equipment, personal clothing or comfort items such as diabetic shoes, wigs, or hygiene items. Bathroom convenience items including but not limited to tub rails, handrails and elevated toilet seats.
25. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.
26. Charges for routine services, such as research studies, screening examination, employment physical, or any related charges, such as premarital lab work, immunizations and other care not associated with treatment or diagnosis of an Illness or Injury, except as stated in this Summary Plan Description.
27. Care that occurred prior to your Effective Date or after your coverage has been terminated.
28. Charges for professional services billed by a Physician or registered Nurse, licensed practical Nurse or licensed vocational Nurse who is an Employee of a Hospital or any other Facility and who is paid by the Hospital or other Facility for the service provided.

29. Charges for Hospital admission on Friday or Saturday unless the admission is an Emergency situation, or Surgery is scheduled within 24 hours. If neither situation applies, Hospital expenses will be payable commencing on the date of actual Surgery.
30. Charges for Inpatient Room and Board in connection with a Hospital stay primarily for diagnostic tests or therapy, unless it is determined by the Plan that Inpatient care is Medically Necessary.
31. Charges not submitted within the Plan's 180 day filing limit deadline.
32. Charges for Illness or Injury suffered by the Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified under subrogation.

Medical Coverage Exclusions

1. Expenses solely for cosmetic procedures or complications from cosmetic procedures, except as specifically stated in this Summary Plan Description.
2. Charges for surgical weight reduction procedures and all related charges.
3. Charges for non-surgical services, supplies, or treatment except as specifically stated in this SPD, primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs for treatment of any condition or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and Hospital Confinements for weight reduction programs.
4. Charges for or in connection with: treatment of Injury or disease of the teeth; oral Surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; dental implants; temporary bridges; dentures; or periodontia, unless specifically defined elsewhere in this Summary Plan Description.
5. Charges for treatment of myofascial pain syndrome including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia and intra-oral prosthetic devices.
6. Charges for services, supplies or treatments for the reversal of sterilization procedures.
7. Coverage for service, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation or gamete intrafallopian transfer (GIFT).
8. Charges for services, supplies or treatment of a sexual dysfunction and inadequacy, including, but not limited to, medications.
9. Doula services
10. Non-legend enteral feeding
11. Charges for refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated in this SPD; dispensing optician's services.
12. Charges for any eye Surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such Surgery; charges for LASIK Surgery.
13. Charges associated with the rental or purchase of Durable Medical Equipment (DME) when rental expense exceeds purchase price, or for replacement of equipment that is less than five years old or that can be repaired.

14. Sales tax on medical supplies/DME items.
15. Over-the-counter DME products
16. Rehabilitation (lift) chairs.
17. Home defibrillators.
18. Take home supplies.
19. Charges for non-human or artificial organ transplants.
20. Harvesting of human organs or bone marrow when the recipient is not a Plan Covered Person.
21. Charges for expenses related to hypnosis.
22. Massage therapy even if provided by a Physical Therapist.
23. Alternative Care programs, acupuncture, acupressure treatments, primal therapy, rolfing, psychodrama, megavitamin therapy, visual perception training.
24. Charges for homeopathic or holistic medicines or providers or naturopathy.
25. Except as Medically Necessary, treatment of plantar fasciitis, metabolic or peripheral-vascular Illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails. Non-covered services also include cosmetic foot care (meds for toenail fungus, flat feet, nail trimming for those without conditions mentioned above.
26. Charges for Custodial Care, nursing home care, rest cures, Domiciliary care regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities.
27. Full body CT scans
28. Quantitative Sensory Testing (QST).
29. Charges for travel or accommodation, whether or not recommended by a Physician, except as specifically provided in this Summary Plan Description.
30. Travel Clinic and related services (e.g., immunizations, medications).
31. Sclerotherapy for spider veins.
32. Unattended electrical stimulation.
33. Cervical home traction units.
34. Charges for harmful habit appliances, such as appliances to control bruxism (teeth grinding) or thumb guards.
35. Stand-by charges of a Physician.
36. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids and nutritional supplements.
37. Charges for procurement and storage of one's own blood, unless Incurred within three months prior to a scheduled Surgery.
38. Charges for Prescription Drugs that are covered under the Prescription Drug Program or for the applicable Prescription Drug Copayment.
39. Charges for wigs, artificial hair pieces, artificial hair transplants or any drug – prescription or otherwise – used to eliminate baldness, unless baldness is result of cancer or cancer treatment. One wig is covered after cancer treatment.
40. Physical therapy services provided by a Chiropractor; and services provided outside the scope of the Chiropractor license.

41. Charges for services and supplies for human organ transplants of any Provider outside the U.S.
42. Charges Incurred outside the U.S. if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, supplies and treatment.
43. Charges for the cost of materials used in occupational therapy.
44. Charges for services, supplies or treatment by a Physician, Facility or Professional Provider beyond the scope of their license or services, supplies or treatment not recommended by or performed by the appropriate Physician, Facility or Professional Provider.
45. Charges for services, supplies or treatment due to an Illness or Injury that results from engaging in a hazardous hobby. A hobby is hazardous if it is an activity that is characterized by a threat of danger or risk of bodily harm. Hazardous hobbies include: auto racing or any kind of organized vehicular speed or endurance contest on land, water or air and stunt driving or aerobatics demonstration or contest. This exclusion does not apply if the Illness or Injury resulted from being the victim of an act of domestic violence or underlying medical condition and is not the result of participation in any of the activities described above.
46. Charges related to acupuncture or acupressure treatment.

Behavioral Health Coverage Exclusions

1. Charges for services, supplies, or treatment for behavior or conduct disorders, development delay, learning disorders, mental retardation or senile deterioration. However the initial examination, office visit and diagnostic testing to determine the Illness shall be a covered benefit, subject to the Plan's Deductible and Copayments.
2. Charges for services for bereavement, marital, religious or family counseling.
3. Charges for biofeedback therapy.
4. Services for mental Illnesses that cannot be treated; however, services to determine if the mental Illness is treatable are covered.
5. Services for weight control or reduction not related to a primary Axis I disorder such as Anorexia or Bulimia.
6. Behavior modification programs unless authorized by IU Health Medical Management Department.
7. Report writing and/or court testimony for any purpose.
8. School meetings for any purpose.
9. Telephone counseling or school meetings by Outpatient Behavioral Health practitioners.
10. Charges incurred as the result of any self-inflicted Injury or Illness, unless the self-inflicted Illness or Injury is otherwise covered by the Plan and if the Covered Person's self-inflicted Injury or Illness is the result of a physical or mental condition or being the victim of an act of domestic violence.
11. Custodial Care, nursing home care, rest cures, Domiciliary care regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities.

IU Health Pharmacy Benefit

The Covered Person pays the Copay or Coinsurance (Coinsurance is a percentage rather than flat Copay amount) listed on the following pages for Covered Charges Incurred by a Covered Person during the calendar year until the individual or family out-of-pocket expense limit has been reached. Thereafter, the Plan pays 100 percent (100%) of Incurred Covered Charges for the remainder of the calendar year.

<table>
<tr><th></th><th>In-Network Retail Pharmacies</th><th>CVS Health Mail Order Pharmacy</th></tr>
<tr><td colspan="3">HDHP High Plan and HDHP Low Plan
Member Cost Per Prescription*</td></tr>
<tr><td>Tier 1 –
Generic</td><td rowspan="3">0% of the prescription cost
(after Deductible satisfied – member pays 100% until the Deductible is met)

30-day max supply</td><td rowspan="2">0% of the prescription cost
(after Deductible satisfied – member pays 100% until the Deductible is met)

90-day max supply</td></tr>
<tr><td>Tier 2 –
Preferred Brand</td></tr>
<tr><td>Tier 3 –
Non-Preferred Brand</td></tr>
<tr><td>Tier 4 –
Specialty; Biotech medications (available only through IU Health and CVS Health Specialty Pharmacies)</td><td>30-day max supply</td></tr>
<tr><td>Preventive Medications</td><td>Yes; $0 Copay</td><td>Yes; $0 Copay</td></tr>
<tr><th></th><th>In-Network Retail Pharmacies</th><th>CVS Health Mail Order Pharmacy</th></tr>
<tr><td colspan="3">Self-Funded HMO Medical Plan
Member Cost Per Prescription*</td></tr>
<tr><td>Tier 1 –
Generic</td><td>30-day: $20</td><td>Up to 90-day: $40</td></tr>
<tr><td>Tier 2 –
Preferred Brand</td><td>30-day: $40</td><td>Up to 90-day: $80</td></tr>
<tr><td>Tier 3 –
Non-Preferred Brand</td><td>30-day: $80</td><td>Up to 90-day: $160</td></tr>
<tr><td>Tier 4 –
Specialty; Biotech medications (available only through IU Health and CVS Health Specialty Pharmacies)</td><td>30-day: 25% ($250 max);
90-day: N/A</td><td>N/A</td></tr>
<tr><td>Preventive Medications</td><td>Yes; $0 Copay</td><td>Yes; $0 Copay</td></tr>
</table>

* Each covered prescription (unique, drug, dose form, and strength) will be subject to Copay or Coinsurance based on its day supply and the Plan design. Each prescription must meet all established Plan criteria including quantity limits, and any other utilization program that is in place such as Prior Authorization, step therapy, or split tablet.

Prescription Drug Benefit

The Plan Prescription Drug benefit utilizes a four-tier drug formulary. A drug formulary is a listing of the Plan covered medications. Each formulary medication is assigned to one of the four tiers, and each tier has a Copay or Coinsurance assigned to it. This leads to appropriate and cost-effective use of pharmaceutical therapies grounded in evidence-based clinical guidelines and can be the key to a successful strategy for improving individual patient outcomes and containing overall healthcare costs.

In this section you will find helpful information about:

- Customer Solutions;
- Network Pharmacies;
- Prescription Drug Benefit;
- Covered Prescription Drugs;
- Prescription Benefit Exclusions;
- Utilization Programs;
- Emergency Medications;
- Prescription Drug Coverage Under Medicare

Customer Solutions

If you have any questions about your pharmacy benefits, contact the pharmacy benefits administrator, for information: 844.432.0704, 24 hours a day, 365 days a year.

Network Pharmacies

Through the Prescription Drug Benefit, there are two options for filling prescriptions:

(a) All network retail pharmacies,
(b) CVS Health Mail Order pharmacy

A listing of the Network Pharmacies is available at iuhealthplans.org.

Present your Plan ID Card at the pharmacy when you have your prescription filled or to obtain a refill. Please note: The pharmacist may ask for the Covered Person's birth date as a check for safety and quality care.

Prescription Drug Benefit

Please refer to the IU Health Plans Pharmacy Benefits information in the Benefits Table Summary. 90 day supplies are available through CVS Health Mail Order pharmacy.

Covered Prescription Drugs

1. Drugs that are on the formulary (listing of covered drugs) and prescribed by a Physician that require a prescription either by federal or state law, except drugs excluded by the

Plan and those not meeting established criteria for coverage (i.e. Quantity limits, Prior Authorization criteria, or other established criteria). *For a complete listing of formulary medications, please refer to* iuhealthplans.org.

a. Formulary insulin, insulin syringes, and needles via a legal prescription.
b. Formulary diabetic testing supplies via a legal prescription.

The benefit applies only when a Covered Person incurs a covered Prescription Drug charge for a formulary medication, meets formulary coverage requirements (i.e. Prior Authorization, step therapy, in addition to quantity limits, etc), and presents a legal prescription to a Network pharmacy.

Prescription Drug Exclusions

The following are not covered under the Outpatient Prescription Drug Rider. Certain Services excluded below may be covered under other benefits of your group. Please refer to the applicable benefit to determine if drugs are covered. Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:

1. Any drug prescribed for intended use other than for:
   - Indications approved by the FDA
   - Off-label indications recognized through peer-reviewed medical literature
2. Any drug prescribed for a sickness or bodily injury not covered under this Plan
3. Drugs that have an active ingredient where at least one drug that contains that active ingredient is covered on the formulary
4. Any drug, medicine, or medication that is either:
   - Labeled, "Caution -- limited by federal law to investigational use"
   - Experimental or investigational or for research purposes
5. Allergen extracts
6. Therapeutic devices or appliances, including, but not limited to:
   - Hypodermic needles and syringes (except needs and syringes for use with insulin and self-administered injectable drugs, whose coverage is approved by us)
   - Support garments
   - Test reagents
   - Mechanical pumps for delivery of medications
   - Other non-medical substances
7. Dietary supplements, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease
8. Nutritional products
9. Minerals
10. Growth hormones for idiopathic short stature
11. Growth hormones, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by us

12. Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride
13. Anabolic steroids, except for use in AIDS Wasting Syndrome or testosterone for laboratory confirmed diagnosis of low testosterone
14. Anorectic or any drug used for the purpose of weight control
15. Any drug used for cosmetic purposes, including, but not limited dermatologicals or stimulants for hair growth, and pigmenting or de-pigmenting agents
16. Any drug or medicine (unless duly noted on the drug list, preferred drug list or formulary) that is:
    - Lawfully obtainable without a prescription (over-the-counter drugs), except insulin
    - Available in prescription strength without a prescription
17. Drugs used to induce abortions
18. Infertility services including medications
19. Any drug prescribed for impotence and/or sexual dysfunction
20. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner
21. The administration of covered medication(s)
22. Prescriptions that are to be taken or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
    - Hospital
    - Skilled nursing facility
    - Hospice facility
23. Injectable drugs, including, but not limited to:
    - Immunizing agents, unless otherwise determined by us.
    - Biological sera
    - Blood
    - Blood plasma
    - Unapproved self-administrated injectable drugs or specialty drugs
24. Prescription refills that exceed the drug-specific refill limit, the number specified by the healthcare practitioner, or the number allowed by law
25. Prescription refills dispensed more than a year from the date of the original order
26. Any portion of a prescription or refill that exceeds a 90-day supply when received from a mail order pharmacy or a retail pharmacy that participates in our program
27. Any portion of a prescription or refill that exceeds a 30-day supply when received from a retail pharmacy that does not participate in our program, which allows you to receive a 90-day supply of a prescription or refill
28. Any portion of a specialty drug of self-administered injectable drug that exceeds a 30-day supply, unless otherwise determined by us

29. Any portion of a prescription or refill that exceeds drug-specific QLL, is dispensed to a covered person whose age is outside the drug-specific age limits defined by us, and/or exceeds the QDL
30. Any drug for which step therapy or prior authorization is required, as determined by the Plan, and not obtained
31. Any drug that typically does not have a customary charge
32. Any drug, medicine, or medication received by you before you became covered under the Plan, or after the date your coverage under this Plan has ended
33. Any costs related to the mailing, sending or delivery of prescription drugs
34. Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than you
35. Any prescription or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged
36. Any drug, medicine, or supply to eliminate or reduce a dependency on, or addiction to, tobacco and tobacco products, unless coverage is mandated per the Affordable Care Act
37. Drug delivery implants
38. Treatment for onychomycosis (nail fungus)
39. More than one prescription or refill for the same drug or equivalent medication prescribed until you have used, or should have used, at least 75 percent of the previous prescription or refill if the drug or therapeutic equivalent medication is purchased through a mail order or a retail pharmacy that participates in our program, and that pharmacy allows you to receive a 90-day supply of a prescription or refill, you must have used, or should have used at least 75 percent of the previous prescription (according to the prescribed dosage schedule)
40. Any amount you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription

These limitations and exclusions apply even if a healthcare practitioner has performed or prescribed a medically appropriate procedure, service, supply, or prescription. This does not prevent your healthcare practitioner or pharmacist from providing or performing the procedure, service, treatment, supply, or prescription. However the procedure, service, treatment, supply, or prescription will not be covered.

Utilization Programs

2017 Pharmacy Benefit Programs					
Program	Description	Plan		Pharmacy Network	
		HMO Plan	HDHP Plans	In-Network Retail Pharmacy	CVS Health Mail Order Pharmacy
Copay Coinsurance	The amount that the member pays per prescription based on its day supply and the plan design the member is enrolled in. Each covered prescription (unique, drug, dose form, and strength) will be subject to a copay or coinsurance. Each prescription must meet all established plan criteria including quantity and age limits, and any other utilization program that is in place such as prior authorization, step therapy, or split tablet.	✓	✓	✓	✓
Mail Order	Mail order is available through the CVS Health Mail Order pharmacy for the same copay/coins as in-network pharmacies.	✓	✓	N/A	✓
90 day supplies	Once established on a long-term maintenance medication, prescriptions may be filled for up to 90 days at a time at IU Health Retail and Mail Order pharmacies.	✓	✓	✓	✓
Specialty Medications	Medications requiring unique monitoring and/or use may be filled for up to a 30 day supply at IU Health Retail and Mail Order pharmacies and CVS Health Specialty Pharmacy.	✓	✓	✓	N/A
$0 Preventive Medications	Members can fill prescriptions on the government mandated preventive medication list for $0.	✓	✓	✓	✓
$0 Diabetic Testing Supplies	Members can fill covered diabetic supplies (including meters, test strips, lancets, control solution, insulin syringes, insulin needles, pen needles, alcohol swabs, and ketone strips) for $0.	✓		✓	✓
Diabetic Supplies Bayer and One Touch Program	Preferred diabetic meters, test strips, and lancets are Bayer and One Touch brands: Bayer Contour®, Bayer Breeze 2®, One Touch Ultra®, One Touch Ultra Mini®, and One Touch Verio IQ®. All other brands will require documentation of medical necessity for coverage.	✓	✓	✓	✓
Mandatory Generic	If a brand medication is dispensed when a generic is available, the member pays the brand copay/coins in addition to the difference in cost between the brand and generic. Please note the additional copayment/coinsurance or penalty amount may exceed any previously stated maximum copayment, deductible, or maximum-out-of-pocket (MOOP) amount.	✓	✓	✓	✓
Step Therapy	This program provides coverage for certain medications after members have met the requirements of having tried similar, previous therapies within the same medication class.	✓	✓	✓	✓
Prior Authorization	Certain prescription medications have prior authorization requirements in place to ensure appropriate utilization prior to filling the prescription.	✓	✓	✓	✓

2017 Pharmacy Benefit Programs					
Program	Description	Plan		Pharmacy Network	
		HMO Plan	HDHP Plans	In-Network Retail Pharmacy	CVS Health Mail Order Pharmacy
Quantity and Age Limits	Limits that are on certain medications to promote appropriate prescribing and/or preferred alternatives.	✓	✓	✓	✓
Pharmacy copay/coinsura	Pharmacy copay/coins count toward the overall plan deductible.	N/A	✓	✓	✓
Pharmacy copay/coinsurance → plan MOOP	Pharmacy copay/coins count toward the overall plan maximum out of pocket (MOOP).	✓	✓	✓	✓

For additional information regarding each program, please see the individual program descriptions and lists on the benefits website at iuhealthplans.org. Additionally any questions can be answered at 844.432.0704.

Emergency Medications

In Emergency situations there are options for filling medications at non-preferred pharmacies for the preferred Copay or Coinsurance when preferred pharmacies are unavailable. This override applies to Emergency prescriptions only, including antibiotics, anti-nausea, asthma rescue medications, and some other short term therapies. This does not include maintenance therapies and regular refills such as blood pressure, cholesterol, and most other prescriptions.

Remember, the reimbursement form continues to be an available option at all times for Emergency circumstances and may be submitted up to 60 days after the prescription is filled. The reimbursement form can be found on the IU Health Plans website at iuhealthplans.org.

In the event that an In-Network Pharmacy is not available for use, ask the pharmacist to call 844.432.0704 so you can fill the prescription at the lower preferred pharmacy copay. The other option for preferred pharmacy copays on emergency prescriptions when an In-Network Pharmacy is not available is to submit a reimbursement form, which is available at iuhealthplans.org.

Prescription Drug Coverage Under Medicare

Effective January 1, 2006, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) added a Prescription Drug program to Medicare (Medicare Part D) for individuals who are enrolled in Medicare.

Individuals initially become entitled to Medicare Part A when they reach age 65 and receive Social Security benefits. An individual is eligible for Medicare Part D Prescription Drug Benefits if covered by Medicare Part A and/or enrolled in Medicare Part B or enrolled in a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug

Plans provide a standard level of coverage set by Medicare. Some Plans may offer more coverage for a higher monthly premium.

Individuals under age 65 may also become entitled to Medicare benefits if they receive at least 24 months of Social Security benefits based on disability.

IU Health Plans has determined that the Prescription Drug coverage offered is, on average for all Plan participants, expected to pay out as much as standard Medicare prescriptions drug coverage and is therefore considered "creditable coverage". Because IU Health Plans coverage is creditable coverage, you can keep this coverage and not pay a higher premium if you later decide to join a Medicare Prescription Drug Plan. You could be subject to higher Part D premiums, however, if you have a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. Team Members can choose not to enroll in a Part D plan or they can enroll in a Part D plan as a supplement to, or in lieu of, the Plan's coverage.

Your Plan coverage pays for other health expenses in addition to Prescription Drugs. If you enroll in a Medicare Prescription Drug plan, you and your eligible Dependents will still be eligible to receive all of your current health and prescription benefits through IU Health Employee Benefits Plan.

If you drop your current medical coverage and enroll in Medicare coverage, you may enroll back into the Plan during an open enrollment period.

Plan enrollees potentially eligible for Medicare Part D include:

- Active working Team Members who become Medicare eligible;
- Dependents (such as spouses of active working Team Members who are Medicare eligible;
- Disabled Dependents (e.g. children) eligible for Medicare; and
- Long-term disability (LTD) recipients who become Medicare-eligible.

If you become Medicare-eligible, it is important that you evaluate both the Plan Prescription Drug benefit and the Medicare Prescription Drug Benefit to determine which program best meets your specific needs. Compare your current coverage, including which drugs are covered, with the drug coverage and cost of the Plans being offered through Medicare before making a decision to enroll with a Medicare program.

Detailed information about Medicare Prescription Drug Plans is available through:

- Medicare's website at www.medicare.gov;
- Calling Medicare at 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048;

The State Health Insurance Assistance Program (see the inside back cover of the "Medicare and You" handbook for telephone numbers).

Section Five:

Plan Administrative Information

MSD of Wayne Township Employee Benefits Plan has contracted with IU Health Plans to provide benefit plan administration to Covered Persons for its self-funded Plan. IU Health Plans provides member services via telephone and online support for questions regarding: benefits, claims processing and claims status, and Network Providers. For more information about Plan administrative services, visit the IU Health Plans website: iuhealthplans.org.

At a Glance

The following information may help IU Health Plans to ensure proper claim payment and locating Plan information:

- **Member Services** – Trained member services representatives are available 7 a.m. – 7 p.m. Eastern Time, Monday-Friday at 800.873.2022 or 317.816.5170. The plan website is: iuhealthplans.org.
- **Accurate Registration –** Make sure that Registration information is correct for each Covered Person by verifying personal information each time you receive healthcare services. Make sure you have a current ID card and the correct ID card is being used, the address information is up-to-date, and the date of birth information is accurate. This ensures timely claim processing. See the section on MSD of Wayne Township Employee Benefits Plan Identification (ID) Card for additional information.
- **Coordination of Benefits (COB) –** COB is the procedure used to pay healthcare expenses when a Covered Person is covered by more than one Plan. You are responsible for providing the medical benefits administrator with information pertaining to additional medical benefits that Covered Persons are eligible to receive. The Plan uses this information for determining payment decisions. See Coordination of Benefits section for additional information.
- **Life Event Changes –** Certain changes that affect you and/or your Dependents, such as a marriage, birth or divorce, may result in the need to make changes to your benefits elections and a corresponding change in premium. See section on Change in Family Status/Life Event Changes for additional information.

Eligibility

You are eligible for benefits if you are full-time (scheduled to work 30 hours per week). Your Dependents eligible for enrollment include:

1. Legally married spouse.
2. Registered domestic partner (same or opposite sex).
3. Children* to the end of the month of their 26th birthday or any age if permanently and totally disabled. (A permanently and totally disabled child must have been continuously covered prior to enrolling in the IU Health Employee Benefit Plan.)

4. Dependent children who are required by a qualified medical child support order (QMCSO) to be covered by the Plan and are (1) not claimed as Dependent with the IRS by the Employee and/or (2) do not reside with the Employee may be covered under the Plan in accordance with such QMCSO. A copy of this order must be furnished to Human Resources at the time of enrollment and determined to be qualified as set forth below. Covered children who reside outside the service area and are required to be covered by the Employee in accordance with a QMCSO are covered at a higher Deductible and Coinsurance for services, but may return to the service area (designated Primary Care Physician) for all routine care for coverage at the lowest Deductible and Coinsurance. Services received are paid per the Plan. (For enrolling Dependents, see section on How You Enroll.)
   *Children include natural or legally adopted children of the Employee, children placed for adoption, stepchild and court-appointed legal guardian.

Coverage Options:

1. **Employee Only –** Covers only the Team Member.
2. **Employee + Children –** Covers the Team Member and eligible children.
3. **Employee + Spouse (domestic partner) –** Covers the Team Member and his/her spouse or domestic partner.
4. **Family –** Covers the Team Member and eligible spouse/domestic partner and eligible Dependents.

Look-back Measurement Method for Determining Full-time Employee Status

MSD of Wayne Township uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.
The look-back measurement method applies to:

- All Employees

The look-back measurement method involves three different periods:

- Measurement period
- Stability period
- Administrative period

The measurement period is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time. If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the standard measurement period and any administrative period.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the "initial measurement period." Your hours of service during the initial measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, MSD of Wayne Township will determine your status as a full-time employee who is eligible for the Plan's health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

The stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee, as established by ACA rules and guidelines, is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of MSD of Wayne Township. There are exceptions to this general rule for employees who experience certain changes in employment status.

An administrative period is a short period between the measurement period and the stability period when MSD of Wayne Township performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days.

However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by MSD of Wayne Township or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation.

MSD of Wayne Township intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

Eligibility Verification

New hires and existing Employees enrolling themselves and/or Dependents in medical, dental and/or vision coverage must provide supporting documentation within 31 days of hire or family status change to the Plan Administrator or their local Human Resources Office for verification of eligibility. Acceptable documentation is outlined below.

If you are enrolling your spouse in medical coverage, you must also complete and submit a Questionnaire for Medical Coverage of a Spouse so a determination can be made on whether the spouse is eligible for primary or secondary coverage through the Plan.

Acceptable Supporting Documentation
(All financial information and Social Security numbers should be marked out.)

- Legal Spouse –A copy of the first page of the most recently filed federal income tax return Form 1040 that indicated "married filing jointly" or "married filing separately" (spouses name must appear on the line provided after "married filing separately"). If recently married and have not filed a joint 1040, Employee must provide a copy of the recent valid legal or religious marriage certificate/license, which must include date of marriage.
- Registered domestic partner (same or opposite sex) – certified tax Dependent – A copy of the first page of the most recently filed federal income tax return Form 1040 indicating domestic partner as your IRC Section 152 Dependent.
- Child/Adult child up to age 26 – A copy of any one of the following: birth certificate, legal adoption papers, official court order, legal guardianship papers, qualified medical child support order.
- Disabled child over the age of 26 – A copy of any one of the above acceptable documents for any child/adult child, the first page of the most recently filed Form 1040 and a statement from a Physician certifying that the Dependent cannot work to provide self-support due to a permanent and total disability.

Acceptable documentation must be provided within 31 days of hire or family status change to Human Resources Shared Services or local Benefits Office for verification of eligibility for an enrolled Dependent for Plan coverage to become effective.

Contact your Human Resources office or Plan Administrator if you have any questions about the eligibility of any Dependents you would like to enroll for coverage.

Special Enrollment Period for Newly Acquired Dependents
If you acquire a new Dependent through birth, adoption, placement for adoption or marriage and submit a change form (along with applicable eligibility documentation) to the Plan Administrator within 31 days of this event, coverage for this Dependent will become effective on the date of the birth, adoption, or placement for adoption. You and your eligible spouse may also enroll during this special enrollment period for newly acquired Dependents. Coverage for this Dependent will begin the first of the following month. If you wait longer than 31 days, the Dependent and/or you and your eligible spouse are considered late enrollees and you must wait until the next annual open enrollment period to apply for coverage. In this case, coverage will not become effective until January 1 following the open enrollment period. If you acquire a new Dependent, you should notify the Plan Administrator and your Human Resources office immediately.

Claims for newborns are paid by the Plan as part of the maternity and delivery charge. This does not mean your baby is covered by the Plan for any services or Hospitalization after mother is discharged from the delivery. Contact the medical benefits administrator if you have any questions.

Note: In all cases, you must complete an enrollment form for the newborn and submit it to Human Resources within 31 days from delivery to ensure there is no break in coverage for your baby. For other newly acquired Dependents, you have 31 days from the date the Dependent is

adopted or placed for adoption in which to provide the above mentioned supporting documentation.

Health Benefit Enrollment Process

Newly Hired and Current Employees

When you begin working at MSD of Wayne Township, you are given an opportunity to enroll in the Employee Benefits Plan the first of the month following your first paycheck. **You must enroll within the first 31 calendar days from the day you are first eligible. If you miss this opportunity, you must wait until the annual benefits open enrollment period.** You may enroll yourself and your eligible Dependents in one of the Plan options. The annual benefits open enrollment period is usually in the Fourth Quarter.

Another opportunity when enrollment changes may occur is during a "special enrollment" that's triggered when there is a life-changing event, such as a marriage, birth or adoption, divorce, etc. Again, you will have 31 days to complete a special enrollment from the date of the family status change.

If you do not enroll within the 31-day period after your initial eligibility or special enrollment, you may enroll during the next open enrollment, which could be months later. When you enroll as a newly hired Employee within 31 days after receiving your first paycheck, your coverage is effective on the first day of the month after the date you send in the enrollment information. The Plan Administrator must receive your enrollment information within the first 31 days after you become eligible.

It takes approximately 15 business days from the time your information is received by the Plan Administrator to the time your benefit selection is processed with the medical benefits administrator. If you receive Covered Services prior to your enrollment information being processed, your claims may be denied. These claims will be adjusted once your enrollment is completed when the medical benefits administrator processes your benefit selections data.

Enrollment Application
Enrollment instructions may be obtained from the Plan Administrator. Completed enrollment information must be returned to Human Resources, not IU Health Plans. Remember to retain a copy of your information for reference.

Plan Premiums
MSD of Wayne Township Employee Benefits Plan shares the premium expense with you for health coverage. Your premium expenses are paid automatically through payroll deduction. Deductions are taken over 26 pay periods. Your premium expenses are paid automatically on a pre-tax basis. Please refer to your Employee handbook for specific premium information.

MSD of Wayne Township Employee Benefits Plan Identification (ID) Card
Your MSD of Wayne Township Employee Benefits Plan Identification (ID) Card will be mailed to your home directly by IU Health Plans. Subscribers will receive an ID card that lists each Covered Person. When you receive your ID Card(s), verify that the information is correct.

For new/changing enrollments, you can expect Human Resources and the medical benefits administrator to process your Information within two-to-three weeks. Promptly submitting your information reduces delays in receiving your ID Cards and helps avoid possible claims issues.

If your ID Card(s) is lost or stolen, you may contact IU Health Plans for a replacement card. Please have the Covered Person's Social Security Number available for the member services representative.

Your ID Card includes the following information:

1. Logos – for your Plan, Provider Network, and travel Network,
2. Benefit option you selected;
3. Name of the Covered Person;
4. Covered Person ID number;
5. Group Name;
6. Copayment and Coinsurance requirements;
7. Member Services contact information;
8. Claim submission mailing address;
9. Pharmacy contact information;
10. Travel Network access information

Managing Your Enrollment: Change in Family Status or Life Event Changes

You are required to keep the Plan option you selected for the Plan year unless you or your Dependents experience a change in family status.

There are three times at which you may change your Plan coverage (drop coverage entirely, add coverage, or add/drop a Dependent's coverage) outside of scheduled open enrollment. You may do so only:

1. During your initial 31 days of eligibility for coverage;
2. During a qualified open enrollment period once each year; or
3. In response to a change in family status.

According to Internal Revenue Service guidelines, the following events are considered **qualifying life events** that would trigger an off-cycle time to make certain benefits changes:

1. Changes in legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment;
2. Changes in the number of Dependents for reasons that include birth, adoption, placement for adoption, the assumption of legal guardianship, or death;
3. Employment status changes, such as an Employee, spouse or Dependent starts a new job or loses a current job;

4. Work schedule changes, such as a reduction or increase in hours of employment for the Employee, spouse, or Dependent, including a switch between Part-time and Full Time, a strike or lockout, or the beginning or end of an unpaid leave of absence;
5. A Dependent satisfies – or no longer satisfies – the Plan requirements for unmarried Dependents because of age, job status or other circumstances;
6. A qualified medical child support court order (QMCSO), or similar order, that requires health coverage for an Employee's child;
7. The Employee, spouse or Dependent qualifies for Medicare or Medicaid under Title XVIII of the Social Security Act. (If this happens, Plan coverage may be cancelled for that individual.)
8. The call-up of an Employee reservist to active duty.
9. A covered Retiree and their Dependents whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

If a qualifying life event occurs and you wish to make a change to health coverage, you must contact the Plan Administrator and your Human Resources office. Adjustments to coverage must be consistent with the changes resulting from the qualifying life event and must be completed within 31 days of the qualifying life event.

Covered Person(s) under another Plan who lose that coverage as a result of one of the life events listed above are eligible to participate in the MSD of Wayne Township Employee Benefits Plan.

Continuation of Medical Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) is a federal statute that allows certain Employees and Dependents be provided with the opportunity to continue your group healthcare coverage on a contributory basis under the following circumstances. The extension of coverage applies to almost all Employee health plans providing medical, dental, Prescription Drug, vision or hearing benefits. You will be able to continue coverage through COBRA by paying 102 percent of the costs of the Plan you choose (100 percent of premium cost plus a two percent administration fee) including any portion formerly paid for by MSD of Wayne Township Employee Benefits Plan.

Qualifying Events: Who, When, and for How Long
If your Plan coverage terminates, you and your covered Dependents may continue Medical Care coverage for up to 18 months:

1. If your employment terminates for any reason, including retirement; or
2. If you lose your coverage due to a reduction in your hours of employment; or
3. If you or a Dependent becomes disabled within the first 60 days of COBRA continuation, coverage may be continued for an additional 11 months (29 months total).

Your covered Dependents (or domestic partner) may continue such coverage under the Plan for up to 36 months:

1. If you die while covered by the Plan; or
2. If you and your spouse are divorced, your marriage is annulled or you are legally separated from your spouse; or
3. If you become eligible for Medicare; or
4. If your Dependent child is no longer eligible for coverage under IU Health Plans.

The 18-month COBRA continuation period may be extended to 29 months from the date of the initial qualifying event if an Employee or qualified family Covered Person is determined to be disabled (for Social Security disability purposes) by the Social Security Administration (SSA) before the end of the first 60 days of COBRA coverage. The individual must notify the third party administrator, of this determination within 60 days of the SSA determination and before the expiration of the original 18-month period.

If the covered Employee terminates employment following a FMLA (Family and Medical Leave Act) leave of absence, the event that will trigger COBRA continuation coverage is the earlier of the dates the covered Employee indicates he or she will not be returning to work or the last day of the FMLA leave of absence.

How to Obtain COBRA Coverage

When coverage terminates, the COBRA third party administrator, will notify qualified beneficiaries within 14 days of being notified by the Plan. Notifications are sent to the last known address. The covered Employee, spouse or covered Dependent must notify the third party administrator in the event of a divorce, legal separation or a child becoming an ineligible Dependent, within 30 days of the last occurring event or the date you or your eligible Dependent would lose coverage on account of such event.

Qualified beneficiaries will have 60 days from the date of loss of coverage or the date of COBRA rights notification, whichever occurs later, to elect COBRA benefits. You must complete the enrollment form and return it to the third party administrator, by the 60-day deadline or you will not be allowed to elect coverage. Once the election is made, your status is on hold until the initial premium is received. Once the initial premium is received, coverage will be reinstated.

There is generally a one- to two-week lag time from when the COBRA Plan Administrator processes the first paid premium and the time the third party administrator is updated.

You will be able to receive covered care during this lag time. However, be prepared to provide proof of insurance or be prepared to resubmit the claim if denied the first time.

If you elect to continue any benefits under COBRA, the first payment must be made no later than 45 days of the election to continue coverage. The first payment covers the period beginning with the date the qualifying event occurred through the date the continuation coverage was elected. Thereafter, monthly payments are due on the first of the month and must be paid within the 31-day grace period following the due date. If premiums are not received by the last day of the month for the month in which they are due, coverage will be terminated, retroactively, to the last day of the previous month.

What Causes COBRA Coverage to End?

COBRA continuation coverage would automatically terminate for the following reasons:

1. Written request by the covered individual.

2. Failure to make a timely payment.
3. If, after electing COBRA, the covered individual becomes entitled to Medicare. (For family Covered Persons other than the Employee, the continuation coverage period begins the day in which the Employee becomes entitled to Medicare and extends for 36 months.)
4. When all group Plans are terminated by the Employer and no other is maintained.
5. If, after electing COBRA, the covered individual becomes covered under another group health plan that does not limit or exclude coverage due to a pre-existing condition exclusion.
6. Completion of the COBRA 18-, 29-, or 36-month continuation period.
7. The qualified beneficiary extends coverage for up to 29 months due to disability, and there has been a final determination that the individual no longer is disabled.

COBRA regulations may change from time to time. The extension of coverage will be provided in accordance with current law. Because COBRA rules are complicated, if you have any questions about eligibility, contact Human Resources Shared Services.

Which Plans are Available?
Qualified beneficiaries who lose coverage under Employer group health, dental or vision plans or the healthcare flexible spending account are allowed to elect to continue at the same or lesser level of coverage as provided on the day before the qualifying event. The same tier of coverage (Employee; Employee/Child(ren); Employee/spouse/domestic partner; Family) may be elected or a qualified beneficiary may elect a combination of lesser levels. For example: if your spouse only needs health coverage and the rest of the family needs dental, this would be a possible selection. The premium rates would correspond to the level of coverage selected. Each qualified beneficiary has individual election rights when choosing to continue coverage under COBRA.

COBRA Coverage Options and Monthly Rates for 2017
The cost for COBRA coverage is 102 percent of the total rate shown for the option your selected. Please note, this is not the Employee portion of premium, but the whole cost of premium plus two percent.

Military/Non-Military Leave and Pay

Indiana University Health also complies with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and the Indiana Military Family Leave Act. These laws encompass time off and compensation parameters for non-working time granted due to:

- Certain military training/obligations and non-military service obligations;
- Time off allowed for certain family Covered Persons of individuals serving in a military capacity.

These laws enable affected Employees to continue their medical coverage in manner similar to COBRA. All Full- and Part-Time Employees are covered by this policy.

Retiree Health Coverage

Eligibility Requirements for Retiree Coverage: A retired Employee will be eligible to continue coverage upon retirement from employment with **MSD of Wayne Township** if the following has been met:

A retired Employee who retires on or after June 30, 1986 may elect coverage for himself, his or her spouse, and Dependents if the following criteria are met:

1. completed twenty (20) years of creditable employment with a public employer, ten (10) years of which must have been completed with MSD of Wayne Township immediately prior to his or her retirement date;
2. completed fifteen (15) years of participation in the Employer's retirement plan on or before his or her retirement date;
3. reached age 55;
4. not eligible for Medicare on his or her retirement date;
5. filed a written request to the MSD of Wayne Township within ninety (90) days after the employee's retirement date or the date he or she begins receiving disability payments; and
6. employee agrees to make timely payment of an amount determined by the Employer but not more than the total amount paid by the Employer and an active Employee for equivalent coverage.

Coverage is available to all retired Employees who meet the defined criteria listed above and to all eligible Dependents of the retired Employee. The retired Employee is required to pay the amount as set by the Plan Administrator.

Medical Leave/Disability Status

If you are on an approved medical leave of absence for more than six months you may be eligible for Medical Leave/Disability Status. If you are approved for Medical Leave/Disability Status, your coverage may be extended. You must make arrangements for continuation of coverage directly with Human Resources Shared Services. See the section on Disability Insurance for additional information about these benefits.

Leave of Absence
If you go on an approved leave of absence, your coverage may continue. You must make arrangements for continuation of coverage directly with Human Resources and the Plan Administrator. See the section on Family and Medical Leave Act (FMLA) regarding approved leaves.

Termination of Coverage

Healthcare coverage may terminate for several reasons. These include:

1. MSD of Wayne Township terminates its Plan.
2. Failure to pay your premiums in a timely fashion.
3. Failure to enroll or re-enroll as required.
4. No longer actively at work.
5. Becoming ineligible.
6. Falsifying your application.
7. Dependents become ineligible.

Coverage terminates the last day of the month in which the event occurs. Coverage may terminate sooner for Dependents if the Employee dies or is divorced. You may elect to extend coverage if Plan coverage is lost due to one of the COBRA-related provisions mentioned in Continuation of Coverage section. If you need to acquire new health coverage, you and your Dependent(s) can obtain certificates of creditable coverage through the third party administrator or through the Plan Administrator.

For Retired Employees, your coverage ends on the earliest of the following:

1. The date the person (Retired Employee, surviving Spouse, or Dependent) becomes eligible for Medicare (i.e., turns 65, etc.);
2. The date the Employer terminates health coverage for active Employees; or
3. The first day of the month for which a person fails to make timely payment of premiums;

In the case of a surviving Spouse:

1. The date of the Spouse's remarriage; or
2. Two (2) years after the death of the Employee

In the case of a Dependent, the date the Dependent fails to meet the definition of a Dependent.

Qualified Medical Child Support Orders (Court-Ordered Dependent Coverage)

Alternate Recipient
An Alternate Recipient is the individual designated as the person to receive healthcare coverage under the QMCSO. An Alternate Recipient shall be treated as a Covered Person for reporting and disclosure purposes, including Form 5500 reporting, receipt of Summary Plan Descriptions and summary annual reports and other communications with Covered Persons.

Notification of Receipt of Child Support Order (QMCSO)
Upon receipt by Human Resources and/or the Plan Administrator of a medical child support order, we will notify the Covered Person and the potential Alternate Recipient that we have received the child support order. The notification shall describe the procedures for determining whether the child support order is a QMCSO as defined in section 609 of the Employee Retirement Income Security Act. The procedures shall permit a potential Alternate

Recipient to designate a representative to receive copies of notices with respect to medical child support order. Within a reasonable period of time after receipt of such order, the Plan Administrator shall determine whether such order is a QMCSO.

Procedures to Determine if Medical Child Support Order is a Qualified Medical Child Support Order

Human Resources Shared Services will review the medical child support order or request legal counsel to review the medical child support order to verify the following items are appropriately addressed in the medical child support order and that any other items that must be addressed under the QMCSO procedures are addressed by the order:

a. The medical child support order must create or recognize the existence of an Alternate Recipient's right to receive benefits for which the participants or beneficiary is eligible under the Plan or to assign those rights;
b. The medical child support order must clearly specify the name and last known mailing address of each Alternate Recipient covered by the order and designate to whom any benefits should be paid on behalf of the Alternate Recipient;
c. The medical child support order must specify in a reasonable description the type of coverage to be provided by the Plan to each Alternate Recipient or the manner in which the type of coverage is to be determined, and such coverage must be available under the Plan;
d. The medical child support order must specify that the order applies to this Plan and the period to which the order applies; and
e. The medical child support order must not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

If the Plan Administrator determines the medical child support order satisfies all of the above requirements, then notification, in writing, will be sent to each of the Alternate Recipient(s) and the Covered Person or beneficiary related to such Alternate Recipient(s) that the order is a QMCSO.

If the Plan Administrator determines the order is not a QMCSO, written notification will be sent to each of the Alternate Recipient(s) and the participant beneficiary related to such Alternate Recipient(s) stating the order is NOT a QMCSO and why the order failed to qualify. The Plan Administrator may take any action permitted under the Plan.

Treatment of Alternate Recipient Under Qualified Medical Child Support Order -- Human Resources and/or the Plan Administrator will treat each Alternate Recipient under a QMCSO as a Covered Person under the Plan for all reporting and disclosure requirements imposed by the Employee Retirement Income Security Act.

Cost of Qualified Medical Child Support Order Benefits – The cost of coverage provided under the QMCSO shall be paid by the party designated as responsible for paying for such coverage in the order. In the event the QMCSO does not specify the party responsible for payment for the Alternate Recipient's coverage under the QMCSO, then the Covered Person or beneficiary of the Plan with custody of the Alternate Recipient shall be responsible for paying such coverage. If no participant has custody of the Alternate Recipient, then the participant or

beneficiary most closely related to the Alternate Recipient shall be responsible for paying for such coverage. If two or more Covered Persons or beneficiaries are related to the Alternate Recipient equally, then such individuals shall pay for the Alternative Recipient's coverage equally.

Qualified Medical Child Support Order and Medicaid – The Alternate Recipient's eligibility for Medicaid shall not be considered when enrolling the Alternate Recipient in the Plan. The Plan shall comply with the Alternate Recipient's assignment rights under Medicaid, if any.

Payments or Reimbursements under a Qualified Medical Child Support Order – The Alternate Recipient or the Alternate Recipient's custodial parent can be paid or reimbursed for any benefit payments due under the Plan to or on behalf of the Alternate Recipient.

Special Enrollment Period for Loss of Other Creditable Coverage

In the event you or your Dependents decline coverage through the Plan due to the existence of other health coverage, and if such other health coverage is subsequently terminated due to:

a. Loss of eligibility for such coverage (loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of the coverage for causes such as making a fraudulent claim or for misrepresentation); or
b. The termination of any company contributions for such coverage, then you and your Dependent(s) may enroll in the Plan.

You must provide a properly completed enrollment form to the Plan Administrator within 31 days of the loss of other coverage or termination of company contribution. In such case, the Effective Date of coverage will be the first day of the month following receipt of the properly completed enrollment form to the Plan Administrator within 31 days.

Note: If a properly completed enrollment form is not received within 31 days, then you and/or your Dependents(s) are considered a late enrollee and must wait until the next annual open enrollment period to apply for coverage.

Employees and Dependents who are or become eligible under the State Children's Health Insurance Program (SCHIP) or Medicaid can enroll in an Employer plan (they are otherwise eligible for) within 60 days of the individual (or Dependent) losing eligibility for the Medicaid or SCHIP program or within 60 days of becoming eligible for premium assistance under Medicaid or SCHIP even though the timing falls outside an open enrollment period and the Employee previously refused Employer coverage. If you enroll during open enrollment, coverage goes into effect on January 1 following the open enrollment period.

Section Six:

Medical Benefits Administrator for the Plan

MSD of Wayne Township Employee Benefits Plan has contracted with IU Health Plans to administer the Plan. IU Health Plans provides member services via telephone and online, and member services representatives respond to questions regarding benefits, claims processing and claim status, Network Providers and travel Networks. In this role, they are responsible for:

1. Covered Person eligibility verification;
2. Benefit coverage determinations;
3. Identification (ID) Cards, their replacement and questions;
4. Primary Care Physician and Network Provider questions;
5. Processing claims;
6. Issuing statements of Explanation of Benefits (EOB);
7. Coordinating benefits if a Covered Person is covered by more than one health Plan;
8. Subrogation processing; and
9. Worker's Compensation coordination.

Specially trained member services representatives will answer questions about your Network; provide additional information about how to receive services; assist you with problems; interpret benefits; process Appeals; check your eligibility; and send you a variety of information upon request. If foreign language service is required, the medical benefits administrator can arrange for this.

We want you to be satisfied with the care and services you receive through MSD of Wayne Township Employee Benefits Plan. We encourage your comments and suggestions, and we will work with you to resolve any concerns that may arise. If you are having difficulty with receiving services through the Plan, it is important to let the Member Services team know right away so that you can be assisted promptly.

The contact information is available on your Plan Identification (ID) Card. You can leave a message on the phone number after hours on business days and during the weekend. Your message will be returned by a member services representative on the following business day.

If you are dissatisfied or have been denied coverage for a service you believe to be a covered benefit, you may initiate a complaint with the Plan. Refer to the section on Covered Person Complaint and Appeals Process.

Effectively Using Your Health Plan

Registration Process and Updated Medical Record

It is important that your Physician's office has you and your Dependents' correct address and telephone number as well as any information about your spouse's Employer and medical insurer. Accurate Registration information helps to ensure that your claim will be paid correctly and in a timely manner. **Remember to bring all applicable health Plan cards with**

you when you receive medical services. The office staff will verify that information in your medical record is up to date.

Covered Persons with a workers' compensation case should advise the appointment scheduler at the time the visit is being scheduled that the visit is related to a work Injury. This notification helps ensure proper claim payment through the Worker's Compensation Board of Indiana.

Claims Information

Using Network Providers when receiving Covered Services, allows you, in most instances, to receive care without sending claims or follow-up paperwork to the medical benefits administrator.

After you receive care and pay any applicable Copayments or Coinsurance, you will receive an Explanation of Benefits (EOB) from IU Health Plans. An EOB is a statement that explains how the claim was paid according to your healthcare coverage and what, if any, amounts you owe.

How to File a Claim

In most cases, the Provider will file claims for you, however, when you do need to submit a claim, you may log on to iuhealthplans.org to access a claim form. Claims should be submitted to:

IU Health Plans
P.O. Box 627
Columbus, IN 47202-0627

When you receive an Explanation of Benefits (EOB) or a bill for Covered Services, be sure to review it carefully to confirm that you have been billed appropriately. Contact IU Health Plans Member Services if you have questions.

If you believe the bill is in error, take these steps to remedy the situation:

- Be sure your doctor's office has a copy of your most current Plan Identification (ID) Card. The office must have your health coverage information in order to file claims accurately and timely. Failure to provide your doctor's office with this information could result in your benefits not being covered.
- Check to make sure it is a bill. Your Plan or your Provider may send you an Explanation of Benefits (EOB) or another type of statement, which shows that services were received and paid or billed to the Plan.
- Is the bill for a service not covered under your Plan benefits or equal to your Coinsurance or Copayments for the services? If so, then you are financially responsible for it and need to pay the Provider.
- Call the Physician's office staff and inquire about the bill. Explain that you are a Covered Person in the Plan and the bill should be sent to the medical benefits administrator for the Plan.

Adverse Benefit Determination
In the event of an Adverse Benefit Determination and a claim for services is denied, the Covered Person will receive written notice of the decision. Refer to the section on Appeals and Complaint Process for the process and associated timelines.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is the process used to pay healthcare expenses when you or an eligible Dependent is covered by more than one healthcare plan, including Medicare. Coordination of Benefits with other insurers helps MSD of Wayne Township achieve cost savings for its Team Member population by avoiding duplication of payments.

If you/your Dependents are covered by more than one insurer, the medical benefits administrator follows rules established by Indiana law to determine which insurer pays first (primary plan) and the obligations of the other insurer (secondary plan). The combined payments of all insurers will not exceed the actual amount of the bills Incurred.

COB Process
All enrollees are required to complete the COB process upon enrollment and in January biannually thereafter.

Process for Determining Which Plan is Primary
To determine which health plan is primary, the Plan has to consider both the coordination of benefits provision of the other health plan and which Covered Person of your family is involved in a claim. The primary insurer will be determined by the **first** of the following that applies:

1. Non-coordinating plan: If you have another group plan that does not coordinate benefits, it will always be primary.
2. Employee: The plan that covers you as an active Employee is always primary and pays before a plan covering the person as a Dependent, laid-off Employee or Retiree.
3. Children:
    a. Birthday Rule – When your children's healthcare expenses are involved, the Plan follows the "Birthday Rule". The birthday rule states that the health plan of parent with the first birthday in the calendar year is always primary for the children. For example, if your birthday is in January and your spouse's birthday is in March, your Plan will be primary for all of your children. The year does not matter.
    b. Gender Rules and other insurer rules – Sometimes a spouse's insurer has other coordination of benefits rules, such as a gender rule, which state's that the father's insurer is always primary. In cases of the gender rule or other specific insurer coordination of benefits rules for children, the Plan will follow the rules of that insurer.
4. Children (parents divorced or separated):
    a. If the court decree makes one parent responsible for healthcare expenses, that parent's insurer is primary.
        i. Note: MSD of Wayne Township Employee Benefits Plan reimburses claims according to its Plan rules (i.e. Network requirements must be followed even if a court decree dictates the MSD of Wayne Township

Employee's Benefits Plan is primary for children living outside of the Network of Providers.

b. If the court decree gives joint custody and does not mention healthcare, the Plan follows the birthday rule.
c. If neither of those rules applies, the order will be determined in accordance with the Indiana Department of Insurance rule on coordination of benefits.

5. Other situations: For all other situations not described previously, the order of benefits will be determined in accordance with the Indiana Department of Insurance rule on coordination of benefits.

How the Medical Benefits Administrator Pays as Primary
If MSD of Wayne Township Employee Benefits Plan is primary, the Plan will pay the full benefit provided by the Plan as if you had no other coverage, provided it is a covered benefit through the Plan and the IU Health Medical Management Department rules have been followed.

How the Medical Benefits Administrator Pays as Secondary
Based on coordination of benefits (COB), if MSD of Wayne Township Employee Benefits Plan is secondary, it will pay only if the services are provided through a Provider. As secondary, the medical benefits administrator payments on the Plan's behalf will be based on the balance left after the primary insurer has paid. A copy of the Explanation of Benefits (EOB) from the primary insurer must be submitted to the medical benefits administrator. The medical benefits administrator will pay no more than that balance. In no event will the medical benefits administrator pay more than it would have paid had the Plan been primary. The medical benefits administrator will pay no more than the "allowable expense" for the healthcare provided. If the allowable expense is lower than the primary insurer's, the medical benefits administrator will use the primary insurer's allowable expense. The primary insurer's allowable expense may be less than the actual bill.

- **The medical benefits administrator will not pay any Copayments or Coinsurance required by the primary insurer.**
- **The medical benefits administrator will pay only for services covered under your primary plan only if you followed all of the procedural requirements including Prior Authorization and Network rules.**
- **If an enrollee or Dependent seeks Covered Services through the Plan, applicable Deductibles must be met before the Plan will reimburse as secondary.**

When the enrollee becomes Medicare-eligible at age 65, the Plan will pay as secondary, as if the Covered Person has Medicare Part B, whether or not the Covered Person is enrolled in Medicare Part B. This means that the Plan will only reimburse 20 percent of the Allowed Amount. This does not apply to actively working age 65 or older Employees.

Enforcement of Coordination of Benefits (COB) Provision
The medical benefits administrator will coordinate benefits provided that the medical benefits administrator is informed by you, or some other person or organization, of your coverage under any other insurer.

In order to apply and enforce this provision or any provision of similar purpose of any other insurer, it is agreed that:

- Any person claiming benefits described through the Plan will furnish the medical benefits administrator with any information that is needed.
- The medical benefits administrator may, without the consent of or notice to any person, release or obtain from any source the necessary information needed to complete the claims adjudication process.

Facility of Payment
If payment is made through any other insurer that the medical benefits administrator should have made under this provision, then the medical benefits administrator has the right to pay whoever is paid under the Plan; the medical benefits administrator will determine the necessary amount under this provision. Amounts so paid are benefits under this Plan and the medical benefits administrator is discharged from liability to the extent of such amounts paid for Covered Services.

Right of Recovery
If the medical benefits administrator pays more for Covered Services than this provision requires, the medical benefits administrator has the right to recover the excess from anyone to or for whom the payment was made. The Covered Person agrees to do whatever is necessary to secure the medical benefits administrator's right to recover the excess amount.

Coordination Disputes
If you disagree with the way the medical benefits administrator has paid a claim, your first attempt to resolve the problem should by contacting IU Health Plans. You must follow the Appeal process outlined in the Coverage Appeals and Complaints Process section.

Section Seven:

GRIEVANCE and APPEAL RIGHTS

Grievance and Appeal

Members may file a Grievance or Appeal for an Adverse Benefit Determination which is a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on among other things:

- A determination of an individual's eligibility for coverage (e.g., rescission), or
- A denial of part of the claim due to the terms of a coverage document regarding Copays, Deductibles, or other cost sharing requirements

Your request for a Grievance or Appeal of an Adverse Benefit Determination may be submitted to:

Medical Grievance or Appeal:

Mail: IU Health Plans
Office of Appeals
PO Box 627
Columbus, Indiana 47202-0627

Fax: 812.314.2543
Phone: 800.873.2022 or 317.816.5170

If you need assistance with filing a Grievance or Appeal contact IU Health Plans Member Services at: 800.873.2022 or 317.816.5170 between the hours of 7 a.m. - 7 p.m. ET Monday through Friday, excluding Holidays. Please have the following information ready when you call:

- Subscriber name
- Patient's name
- Subscriber's Health Plan identification number
- The nature of the Grievance or Appeal

Grievance

You may request a Grievance but it must be requested within One hundred and eighty (180) days from the receipt of the initial Adverse Benefit Determination. Receipt of the Adverse Benefit Determination will be presumed three (3) business days from the date of postmark.

When the Grievance is received, it will be recorded in the Plan's records so that it can be tracked and resolved. A file will be opened and maintained throughout the case resolution,

documenting the substance of the Grievance and any action taken. You have the right to submit written comments, documents, or other information related to the Grievance.

You will be mailed an acknowledgment of your Grievance or Appeal request within three (3) business days after receipt by the Plan.

Appeals

If the Grievance was not resolved to your satisfaction, you may Appeal within thirty (30) days from the Grievance decision by writing to the Office of Appeals. Please address your request for an Appeal to the same address as above or call as described above.

You will be mailed an acknowledgement of your Appeal request for review by the Appeal Panel within three (3) business days after receipt by the Plan.

When the Appeal is received, it will be recorded in the Plan's records so that it can be tracked and resolved. A file will be opened and maintained throughout the case resolution, documenting the substance of the Appeal and any action taken. You have the right to submit written comments, documents, or other information related to the Appeal.

The Appeal will be reviewed by the Appeals Panel which in the case of an Appeal regarding Medical Care or treatment, will be composed of one or more individuals who have knowledge of the medical condition, procedure, or treatment at issue. The individuals will be in the same licensed profession as the provider which proposed, refused or delivered the health care, procedure, treatment or service in question and who was not involved in the matter giving rise to the Appeal.

Expedited Grievance and Appeal

IU Health Plans offers the member an expedited Grievance or Appeal for any Urgent Care request that meets the definition of urgent which is: an Adverse Benefit Determination related to an Illness, disease, condition or Injury or a disability that with respect to which if you followed non urgent timelines would seriously jeopardize the member's:

- Life or health
- Ability to reach and maintain maximum function
- In the opinion of the treating Physician or layperson's judgment would subject the Member to severe pain that cannot be adequately treated without the care and treatment that is subject of the Grievance or Appeal.

The timeframe for an expedited review begins when a member or representative of the member, or a practitioner acting on behalf of the member requests an expedited Grievance or Appeal either verbally, by fax, or in writing.

External Review

If you are dissatisfied with our decision of the Appeal, you have the option for certain types of claims; to request External Review by an Independent Review Organization (IRO).The types of

claims are limited to those involving medical judgment, including but not limited to the following:

- Medical necessity denials
- Appropriateness
- Health care setting
- Level of care
- Effectiveness of a covered benefit
- Treatment is Experimental or Investigational

Or:

A rescission of coverage

If you choose to request External Review of your Appeal, send a notice in writing one hundred and twenty (120) days from receipt of the Appeal decision. Receipt will be presumed three (3) business days from the date of postmark.

When filing a request for External Review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the External Review. You may submit additional information to the IRO in writing. You will be allowed five (5) business days to submit the additional information you want considered by the reviewer. The decision of the IRO will be binding on the Plan. An expedited process will be available for urgent claims; you will not bear any costs or filing fees associated with the IRO review. You cannot file more than one (1) External Review request for each Appeal.

Grievance and Appeal Decision Timeframes

Grievances and Appeals of Adverse Benefit Determinations will be resolved according to the following time frames:

- *Pre-Service (Non-Urgent)*: A pre-service Grievance or Appeal is a request to change an Adverse Benefit Determination for care of services in advance of the member obtaining the care of services. IU Health Plans resolves pre-service Grievances or Appeals within fifteen (15) days from receipt of the request at each level of review.

- *Post Service*: A post service Grievance or Appeal is a request to change an Adverse Benefit Determination for care or services that have already been received by the member. IU Health Plans resolves post service Grievances or Appeals within thirty (30) days from receipt of the request at each level of review.

- *Expedited (Urgent)*: An expedited Grievance or Appeal is a request to change an Adverse Benefit Determination for an Urgent Care request by the member. IU Health Plans resolves expedited Grievances or Appeals as expeditiously as the medical condition requires but no later than seventy-two (72) hours after the request for review unless the request fails to provide sufficient information to determine whether or not or to what extent, benefits are covered or payable under the plan in which case the member will be notified of the deficiency within the seventy-two (72) hour timeframe.

- *External Review*: An External Review is an Appeal request to change an Adverse Benefit Determination for certain types of claims if a member is dissatisfied with an Appeal decision. An Independent Review Organization (IRO) will make a determination within fifteen (15) business days after the external Appeal is filed, or for expedited requests, within seventy-two (72) hours after the external Appeal is filed.

Right to Receive Information

For any level of Grievance or Appeal, you are entitled to receive, upon request, reasonable access and copies of all documents relevant to the Grievance or Appeal. Relevant documents include documents or records relied upon in making the decision and documents and records submitted in the course of making the decision. You are entitled to receive, upon request, a copy of the actual benefit provision, guideline, protocol or similar criterion on which the decision was based. You have the right to have billing and diagnosis codes sent to you as well. You may request copies of the information by contacting IU Health Plans Member Services at 800.873.2022 or 317.816.5170 between the hours of 7 a.m. - 7 p.m. ET Monday through Friday, excluding Holidays. You are not required to bear any costs associated with these requests.

Designating a Representative

Covered Persons have the right to designate an Authorized Representative to file a Grievance and, if the Grievance decision is adverse to the Covered Person, an Appeal, with the Plan on the Covered Person's behalf and to represent the Covered Person in a Grievance or an Appeal. An Authorized Representative includes:

1. A person to whom a Covered Person has given express written consent to represent the Covered Person with respect to a claim for benefits for a Grievance or Appeal;
2. A person authorized by law to provide substituted consent for a Covered Person; or
3. A family member of the Covered Person or the Covered Person’s treating healthcare professional only when the Covered Person is unable to provide consent; or
4. Requests for Precertification and other Pre-Service claims or requests by a person or entity other than the Covered Person may be processed without a written authorization if the request or claim appears to the Clinical Appeals Coordinator to come from a reasonably appropriate and reliable source (e.g. Physician’s office, individuals identifying themselves as immediate relatives, etc.)

ADDITIONAL APPEAL RIGHTS FOR MEMBERS OF SELF-FUNDED SCHOOL PLAN

Pursuant to Indiana law governing self-funded health plans for school districts, MSD of Wayne Township members have an additional right of appeal. If, after all preceding appeals are exhausted, and the issue is not resolved to the member’s satisfaction, an additional appeal may be taken. All of the preceding rules apply, with the exception of the composition of the appeals panel.

In this instance, an appeals panel will be convened, and will consist of a balanced number of administration and non-administration personnel, and will be balanced consistently with the population of members covered by this Plan.

The panel will be appointed by the Plan Administrator, and the time and location of the meeting will be furnished to the appellant. After the appeal meeting, times for response will be the same as listed in Grievance and Appeal Decision Timeframes, above.

To initiate this final appeal, please submit your request to:

Medical Grievance or Appeal:

Mail: IU Health Plans
Office of Appeals
PO Box 627
Columbus, Indiana 47202-0627

Fax: 812.314.2543
Phone: 800.873.2022 or 317.816.5170

Please note that the appeal is a final appeal under the Wayne Township Plan.

Questions or Concerns

Contact IU Health Plans Member Services at 800.873.2022 or 317.816.5170 between the hours of 7 a.m. - 7 p.m. ET Monday through Friday, excluding Holidays.

Section Eight:

Employee's Rights and Responsibilities

Reimbursement and Subrogation Rights of the Plan

This section of the Summary Plan Description addresses MSD of Wayne Township Employee Benefits Plan's (Plan) "subrogation" and "reimbursement" rights. The terms "Covered Person", "Third Party", "Claim", and "Claim Proceeds" are defined under Definitions in this section.

1. This Plan does not provide any benefits to a Covered Person to the extent that there is any other type of non-healthcare insurance coverage that would provide reimbursement for a Covered Person's medical expenses (including auto insurance that provides underinsured and non-insured motorist coverage, and insurance maintained by MSD of Wayne Township on Employees and insurance maintained by other Employers).
2. If a Covered Person has a Claim against a Third Party, this Plan will provide benefits to, or on behalf of, a Covered Person only under the following terms and conditions:
    a. To the extent that benefits are provided under this Plan, the Plan shall be subrogated to all of the Covered Person's claims against any Third Party. The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure the subrogation rights of the Plan. The Covered Person shall do nothing to prejudice the subrogation rights of the Plan. By submitting a Claim for benefits under the Plan, the Covered Person hereby agrees to cooperate with the Plan and/or any representatives of the Plan in completing the subrogation forms and in giving such information surrounding any accident or other set of facts and circumstances as the Plan or its representatives deem necessary to fully investigate and enforce the Plan's subrogation rights.
    b. The Plan is also granted a right of reimbursement from any Claim Proceeds. This right of reimbursement is cumulative with, and not exclusive of, the subrogation right granted in paragraph (a), but only to the extent of the benefits provided under this Plan.
    c. The Plan is also granted a right of reimbursement from any Claim Proceeds intended for, payable to, or received by the Covered Person or his/her representatives, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. The Covered Person agrees that said lien shall constitute a charge upon the Claim Proceeds and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the Plan, the Covered Person and his/her representatives agree to hold the Claim Proceeds in trust for the benefit of the Plan to the extent of 100 percent of all benefits paid by the Plan on behalf of the Covered Person.
    d. The subrogation and reimbursement rights and liens apply to any Claim Proceeds received or payable to the Covered Person, including but not limited to the following:

i. Payments made directly by Third Party tortfeasor, or any insurance company on behalf of a Third Party tortfeasor, or any other payments on behalf of a Third Party tortfeasor.
ii. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.
iii. Any other payments from any source designed or intended to compensate a Covered Person for injuries sustained as a result of negligence or alleged negligence of a Third Party.
iv. Any workers compensation award or settlement.
v. Any recovery made pursuant to no-fault insurance.
vi. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

e. No adult Covered Person hereunder may assign any rights that such person may have to recover medical expenses from any Third Party to any minor child or children of said adult Covered Person without the prior express written consent of the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
f. No Covered Person shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.
g. The Plan's rights of subrogation and reimbursement shall be a prior lien against any claim proceeds and shall not be defeated nor reduced by the application of any so-called "Make-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages. Accordingly, the Plan's rights of subrogation and reimbursement provide the Plan with the right to receive the first dollars of any Claim Proceeds, irrespective of whether the Covered Person has been fully compensated or partially compensated for all or any of injuries, damages or other claims of the Covered Person.
h. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs or attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," or "Common Fund Doctrine," or "Attorney's Funds Doctrine."
i. The Plan shall recover the full amount of benefits provided hereunder without regard to any Claim of fault on the part of any Covered Person, whether under comparative negligence or otherwise.
j. The benefits under this Plan are secondary to any coverage under no-fault or similar insurance.
k. In the event that a Covered Person shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs Incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligations against any entitlement to future medical benefits hereunder until the Covered Person has fully complied with his reimbursement

obligations hereunder, regardless of how those future medical benefits are Incurred.

For purposes of this Section:

"Claim" means any type of legal, equitable, insurance, or other claim that a Covered Person (or any representative of the Covered Person) has against a Third Party, if that Claim could, or would, provide any amount of money or other consideration to the Covered Person because of, or in any way attributable to, the Covered Person's Claim for benefits under this Plan, or because of any set of facts and circumstances that are in any way related to the Covered Person's Claim for benefits under the Plan. The reference to a Covered Person's Claims includes, without limitation, Claims of pain and suffering and loss of consortium, as well as Claims for consequential, punitive, exemplary or other damages.

"Claim Proceeds" includes any money or other consideration recovered from, or payable by, any Third Party that is attributable to a Claim of a Covered Person. Claim Proceeds includes, without limitation, amounts received by settlement, judgment or otherwise, and any insurance proceeds of any kind, or in satisfaction of any judgment or settlement, insurance claim of any kind, or otherwise. Claim Proceeds includes, without limitation, proceeds received by a Covered Person for Claims of pain and suffering, loss of consortium, consequential, punitive, exemplary or other damages.

"Covered Person" includes, individually and collectively, a participant, beneficiary or any other Covered Person under this Plan. A reference to a Covered Person includes the Covered Person's estate and any representative of the Covered Person.

"Third Party" refers to any person or entity who, with respect to a Claim for benefits of a Covered Person, is not a Covered Person (e.g., a Third Party tortfeasor). References to a Third Party include, without limitation, any auto or other insurer that provides coverage of any kind (including non-insured or underinsured motorists coverage) to the Covered Person or to any Third Party, including insurers that provide coverage to Employees of MSD of Wayne Township or another Employer. The term Third Party also may refer to another person who is a Covered Person under this Plan.

Discrimination is Against the Law

Indiana University Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Indiana University Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Indiana University Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Allison Shelton.

If you believe that Indiana University Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Allison Shelton, Civil Rights Coordinator, Indiana University Health Plans, 950 N Meridian St, Suite 400, Indianapolis, IN 46204, (317) 963-9788, TTY: (800) 743-3333, Fax (317) 963-9801, ashelton@iuhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Allison Shelton, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

English: ATTENTION: Our Member Services department has free language interpreter services available for non-English speakers. Call 855.413.2432. (TTY: 800.743.3333)

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.413.2432 (TTY: 800.743.3333).

Chinese:注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855.413.2432（TTY: 800.743.3333）。

Burmese:

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်

စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 855.413.2432 (TTY: 800.743.3333) သို့ ခေါ်ဆိုပါ။

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855.413.2432 (TTY: 800.743.3333).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855.413.2432 (ATS : 800.743.3333).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855.413.2432 (TTY: 800.743.3333).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855.413.2432 (TTY: 800.743.3333).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855.413.2432 (TTY: 800.743.3333)번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855.413.2432 (телетайп: 800.743.3333).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 855.413.2432 (رقم هاتف الصم والبكم: 800.743.3333).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 855.413.2432 (TTY: 800.743.3333) पर कॉल करें।

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 855.413.2432 TDD/TTY 800.743.3333 uffrufe.

Dutch: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 855.413.2432 (TDD/TTY 800.743.3333).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 855.413.2432 (TTY: 800.743.3333) 'ਤੇ ਕਾਲ ਕਰੋ।

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。855.413.2432（TTY: 800.743.3333）まで、お電話にてご連絡ください。

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a federal law that pertains to group health plans. HIPAA has the following three basic provisions:

- It prohibits an Employer health Plan from imposing pre-existing conditions exclusions on Employees and Dependents, except in limited, specified circumstances and for limited periods of time.
- It prohibits an Employer health Plan from prohibiting enrollment or charging a higher Employee contribution amount or premium because of "health status-related factors."
- It requires an Employer health Plan to allow enrollment for Employees and Dependents who lose coverage under other plans or insurance policies.

HIPAA Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by the Plan to carry out payment, healthcare operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care Provider, a health Plan, your Employer (when functioning on behalf of the group health Plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or Mental Health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact: IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday.

Effective Date

This Notice of Privacy Practices becomes effective on January 1, 2017.

Our Responsibilities

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available by posting on the IU Health Plans website at iuhealthplans.org.

Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

Payment and Health Care Operations

We have the right to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

- *Payment* - We will use *or dis*close your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was Medically Necessary.

- *Health Care Operations* - We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

- *Required by Law* - We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

- *Public Health Activities* - We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, Injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- *Health Oversight Activities* - We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

- *Abuse or Neglect* - We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

- *Legal Proceedings* - We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- *Law Enforcement* - Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

- *Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations* - We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may

disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- *Research* - We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

- *To Prevent a Serious Threat to Health or Safety* - Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- *Military Activity and National Security, Protective Services* - Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

- *Inmates* - If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

- *Workers' Compensation* - We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or Illnesses.

- *Emergency Situations* - We may disclose your PHI in an Emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

- *Fundraising Activities* - We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- *Group Health Plan Disclosures* - We may disclose your PHI to a sponsor of the group health plan – such as an Employer or other entity – that is providing a health care

program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

- *Underwriting Purposes* - We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

- *Others Involved in Your Health Care* - Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

  If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of Your PHI that Require Your Authorization

- *Sale of PHI* - We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

- *Marketing* - We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

- *Psychotherapy Notes* - We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

- *Disclosures to the Secretary of the U.S. Department of Health and Human Services*

We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

- *Disclosures to You* - We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

  We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

  Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

- *Business Associates* - We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy.

- *Other Covered Entities* - We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that

we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- *Plan Sponsor* - We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, Mental Health, substance abuse/Chemical Dependency, genetic testing, reproductive rights, etc.

Your Rights

The following is a description of your rights with respect to your PHI.

- *Right to Request a Restriction* - You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide Emergency treatment to you. You may request a restriction by contacting IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

  We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- *Right to Request Confidential Communications* - If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

  You may request a restriction by contacting IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. It is

important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.,* an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within seven business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice *as soon as* you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for *all* your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

- *Right to Inspect and Copy* - You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

  To inspect and copy your PHI that is contained in a designated record set, you must submit your request to IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated

contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

- *Right to Amend* - If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

  In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- *Right of an Accounting* - You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

  An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

  You may request an accounting by submitting your request in writing to IU Health Plans, P.O. Box 627, Columbus, IN 47202-2808. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list.
We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are Incurred.

- *Right to a Copy of This Notice* - You have the right to request a copy of this Notice at any time by contacting IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

Complaints

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at IU Health Plans Member Services at 800.873.2022 or 317.816.5170, 7 a.m.-7 p.m. Eastern Time, Monday-Friday. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Section Nine:

Definition of Terms

Certain words, phrases or terms used in this Summary Plan Description (SPD) shall be defined as follows and shown with an initial capital letter.

Adverse Benefit Determination - A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit.

Against Medical Advice (AMA) – The act of an individual leaving the care of a medical Facility without proper discharge by a Physician.

Allowed Amount – Negotiated charges for allowed health care services as described in this Summary Plan Description.

Alternate Recipient – Any child of an Employee or their spouse who is recognized in the Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan.

Ambulatory Surgical Facility – A Facility Provider with an organized staff of Physicians, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by the Plan, which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an Outpatient basis;
2. Provides treatment to Covered Persons by or under the supervision of Physicians and nursing services;
3. Does not provide Inpatient accommodations; and
4. Is not, other than incidentally, a Facility used as an office or clinic for the private practice of a Physician.

Appeal - An oral or written request from a Covered Person, Authorized Representative or Provider to review a previous decision or Grievance again.

Authorized Representative – An individual who the Covered Person has authorized in writing to represent or act on their behalf with regards to a claim. An assignment of benefits does not constitute a written authorization for a Provider to act as an Authorized Representative of a Covered Person.

Behavioral/Mental Health Disorder – An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Benefits Period –The period of time specified in the Schedule of Benefits during which Covered Services are rendered and benefit maximums are accumulated; the first and last benefit periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

Birthing Center – A Facility that meets professionally recognized standards and all of the following tests:

1. It mainly provides an Outpatient setting for childbirth following a normal, uncomplicated pregnancy, in a home-like atmosphere.
2. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the Facility; (c) laboratory diagnostic facilities; and (d) Emergency equipment, trays, and supplies for use in life-threatening situations.
3. It has a medical staff that (a) is supervised Full Time by a Physician; and (b) includes a registered Nurse at all times when Covered Person are at the Facility.
4. It is not part of a Hospital. It has written agreement(s) with a local Hospital(s) and a local ambulance company for the immediate transfer of Covered Persons who develop complications or who require either pre- or post-natal care.
5. It admits only Covered Persons who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.
6. It schedules Confinements of not more than 24 hours for a birth.
7. It maintains medical records for each Covered Person.
8. It complies with all licensing and other legal requirements that apply.
9. It is not the office or clinic of one or more Physicians or a specialized Facility other than a Birthing Center.

Chemical Dependency – A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM III-R (Diagnostic and Statistical Manual of Mental Disorders) criteria.

Chiropractic Care -- Services as provided by a licensed chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck extremities or other joints, other than for a fracture or Surgery.

Claims Processor – The entity contracted by the Employer, which is responsible for the processing of claims for benefits under the terms of the Plan and other administrative services deemed necessary for the operation of the Plan as delegated by the Employer.

Clinically Appropriate/Medically Necessary -- A service, supply, and/or Prescription Drug that is required to diagnose or treat conditions the Plan (administered through the medical benefits administrator) determines is:

- Appropriate with regard to the standards of good medical practice;

- Not primarily for convenience or the convenience of a Provider or another person; and
- The most appropriate supply or level of service that can be safely provided to the Covered Person. When applied to the care of an Inpatient, this means that the Covered Person's medical symptoms or condition requires that the services cannot be safely or adequately provided as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost-effective compared to alternative Prescription Drugs that produce comparable effective clinical results.

The fact that a Provider may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment Medically Necessary. In making the determination of whether a service or supply was Clinically Appropriate, the Plan Administrator, or its designee, may request and rely upon the opinion of a Physician(s). The determination of the Plan Administrator or its designee could be followed by an External Review, which would be binding.

Close Relative – The Subscriber's spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the Subscriber's spouse.

Coinsurance –The payment the Team Member owes for services rendered when the Plan coverage is less than 100 percent; Coinsurance is applied to covered expenses after the Deductible(s) have been met, if applicable.

Concurrent Review – A review by the Medical Management Department, which occurs during the Covered Person's Hospital stay or during the course of a prescribed treatment to determine if continued care is Medically Necessary.

Confinement – A continuous stay in a Hospital, Treatment Center, Extended Care Facility, Hospice, or Birthing Center due to an Illness or Injury diagnosed by a Physician. Later stays shall be deemed part of the original Confinement unless there was either complete recovery during the interim from the Illness or Injury causing the initial stay or unless the latter stay results from a cause unrelated to the Illness or Injury causing the initial stay.

Partial Confinement – A period of less than 24 hours of active treatment in a Facility licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services;
2. Treatment of Behavioral/Mental Health
3. Alcoholism treatment;
4. Chemical Dependency treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Copayment/Copay – A cost-sharing arrangement whereby a Covered Person pays a set amount to a Provider for a specific service at the time the service is provided.

Cosmetic Surgery – Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Services /Charges – Charges for medical services, procedures or treatments that are Medically Necessary and covered by the Plan.

Covered Person – A person who has satisfied the Plan's eligibility requirements; applied for coverage; been approved by the Plan; and for whom premium payments have been made and coverage is in effect. Covered Persons are sometimes called "you" and "your".

Custodial Care – Care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting the activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes, but is not limited to:

1. Administration of medication which can be self-administered or administered by a lay person; or
2. Help in walking, bathing, dressing, feeding, or the preparation of special diets.

Room and Board and Extended Care/skilled nursing services are not considered Custodial Care if (1) provided during a stay in an institution for which coverage is available under this Plan, and (2) combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the Covered Person's medical condition.

Customary and Reasonable Amount -- The maximum Allowed Amount for a Covered Service should be calculated using the following criteria:

1. The amount will generally not exceed the actual amount billed by the Physician or other health care Provider for a given service and for some services may be the amount billed.
2. The amount may be limited to the customary charge based on the distribution of charges billed by all Physicians and other health care Providers for a given service within a given specialty and geographic area.
3. The amount must also be reasonable as defined by the Plan medical benefits administrator with respect to customary charges or costs for services of comparable complexity and difficulty.

The Customary and Reasonable Amount is determined from a statistical review and analysis of the charges for a given procedure in a given geographic area. The term "geographic area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage for the applicable Plan is applied to CPT and CDT codes or HIAA Code Analysis using MDR tables.

Deductible – An amount, usually stated in dollars, for which the Subscriber is responsible each benefit period before the Plan starts to pay for health care coverage.

Dependents – For a complete definition, refer to the sections on eligibility and Dependent eligibility.

Developmental Delay – Refers to a lag in acquiring basic skills in children especially when compared to how other children their own age are functioning. Delays in motor skills (ability to

walk or ability or hold onto objects), communication skills (hearing and speaking), cognitive/mental skills (visual integration with an inability to understand what is seen, for example, dyslexia) and social skills (responding to the feelings of others).

Domiciliary -- A temporary residence.

Durable Medical Equipment (DME) – Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered Durable Medical Equipment (DME). DME includes, but is not limited to: crutches, wheelchairs, Hospital beds, etc…

Effective Date – The date when a Subscriber's coverage begins under the Plan.

Emergency – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or, in the case of a pregnant member, the health of the member or the unborn child; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
- Examples of Emergency medical conditions include, but are not limited to:
    - Chest pain
    - Stroke/CVA
    - Loss of consciousness
    - Hemorrhage
    - Multiple traumas.

An Emergency condition may or may not result in an Inpatient Hospital admission.

Employee – A person directly involved in the regular business of and compensated for services by the Employer, who is regularly scheduled to work not less than 72 hours per pay period on a full-time status or 48 hours per pay period on a part-time basis.

Employer – The Employer is MSD of Wayne Township.

Expedited External Review – A request to change an Adverse Benefit Determination made by the Medical Management Department for care or services that involve a medical condition where a delay would seriously jeopardize the life or health of the Covered Person or his/her ability to regain maximum function.

Experimental/Investigational – Services, supplies, and treatment which do not constitute accepted medical practice within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time the services were rendered.

The Plan Administrator or its designee must make an evaluation of the Experimental/non-Experimental standings of specific technologies. The Plan Administrator or its designee shall be guided by a reasonable interpretation of Plan provisions and information provided by other qualified sources who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The Plan Administrator or its designee will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the Covered Person's informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating Facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is in the research, Experimental, study or Investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety and its efficacy as compared with a standard mans of treatment or diagnosis; or
4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating Facility or by another Facility studying substantially the same drug, device, medical treatment or procedure.

Explanation of Benefits (EOB) – A statement received by the Covered Person from the medical benefits administrator after services have been rendered that explains how the bill was paid.

Extended Care/Skilled Nursing Facility – An institution or distinct part thereof, operated pursuant to law and one that meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Illness or Injury, professional nursing services, and physical restoration services to assist Covered Persons to reach a degree of body functioning to

permit self-care in essential daily living activities. Such services must be rendered by a registered Nurse (RN) or by a licensed practical Nurse under the direction of an RN.
2. Its services are provided for compensation and under the full-time supervision of a Physician or RN.
3. It provides nursing services 24 hours per day.
4. It maintains a complete medical record on each Covered Person.
5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of Mental and nervous disorders.
6. It is approved and licensed by Medicare.

External Review – A request to change an Adverse Benefit Determination made by the Plan Administrator or Medical Management Department for denial of eligibility or care or services when the Covered Person has exhausted the Plan's internal Appeal process.

Facility – A health care institution which meets all applicable state or local licensure requirements, including freestanding dialysis Facility, a lithotripter center or an Outpatient imaging center.

Full time – The Team Member's regularly scheduled work not less than 72 hours per pay period.

Generic/Generic Drug – A Prescription Drug that is available and generally equivalent to the brand name drug. The drug must meet U.S. Food and Drug Administration (FDA) bioavailability standards.

Grievance - An expression of dissatisfaction, either oral or written regarding an Adverse Benefit Determination from a Covered Person or Covered Person's Authorized Representative.

Home Health Aide Services – Those medical services which may be provided by a person, other than a registered Nurse, which are Medically Necessary for the proper care and treatment of a Covered Person.

Home Healthcare Agency – An agency or organization that meets the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one Physician and at least one registered Nurse. It must provide for full-time supervision of such services by a Physician or registered Nurse.
3. It maintains a complete medical record on each Covered Person.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under Medicare.

Hospice – An agency that provides counseling and medical services and may provide Room and Board to a terminally ill Covered Person and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service 24 hours-per-day, seven days a week.
3. It is under the direct supervision of a Physician.
4. It has a Nurse coordinator who is a registered Nurse.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of Hospice services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the Covered Person.
9. It is licensed, if licensing is required.

Hospital – An institution that meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to Hospitals.
2. It is engaged primarily in providing Medical Care and treatment to ill and injured persons on an Inpatient basis at the Covered Person's expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or Injury; and such treatment is provided by or under the supervision of a Physician with continuous 24-hour nursing services by or under the supervision of registered Nurses.
4. It qualifies as a Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.
5. It must be approved by Medicare.

Under no circumstances will a Hospital be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

A Hospital shall include a Facility designed exclusively for rehabilitative services where the Covered Person received treatment as a result of an Illness or Injury.

The term Hospital, when used in conjunction with Inpatient stay for Behavioral/Mental Health or Chemical Dependency, will be deemed to include an institution which is licensed as a Mental Health Hospital or Chemical Dependency rehabilitation and/or detoxification Facility by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Identification (ID) Card – A card provided to individuals having Plan coverage listing the individual's name, group number, and important contact phone numbers to call to verify coverage for health and Prescription services. The Covered Person should carry the ID Card with him/her at all times.

Illness – A bodily disorder or disease of a Covered Person.

Incurred or Incurred Date – With respect to a Covered Person, the date the services, supplies or treatment are provided.

Independent Review Organization (IRO) – An outside entity that is accredited by URAC or a similarly nationally recognized accrediting organization to conduct External Reviews. The Plan

Administrator will contract with a minimum of three IROs and assignment of External Reviews will be based upon a rotating assignment methodology.

Injury – A physical harm or disability that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient – A Covered Person who receives healthcare as a registered bed patient in a Hospital or other Facility Provider where a Room and Board charge is made.

Maximum Benefit – The maximum amount paid by this Plan for any one Covered Person for a particular Covered Service. The maximum amount can be for a specified period of time such as a calendar year.

The maximum number the Plan acknowledges as a Covered Service. The maximum number relates to the number of:

- Treatments during a specified period of time; or
- Days of Facility stay; or
- Visits by a Home Healthcare Agency.

Medical care – Professional services received from a Physician or another healthcare Provider to treat a condition.

Medical Management – A comprehensive Physician-directed program utilizing registered Nurses to provide education and follow-up to Team Members to assure the delivery of Clinically Appropriate, high quality, and cost-effective healthcare in the most appropriate setting. The IU Health Medical Management Department provides these services.

Medically Necessary – See Clinically Appropriate

Medicare – The program established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits for the Aged; Part B, Supplementary Medical Insurance Benefits for the Aged; Part C, Miscellaneous provisions regarding all programs; and Part D, Prescription Drug Benefits; and including any subsequent changes or additions to those programs.

Morbid Obesity – A diagnosed condition in which the body weight is one hundred (100) pounds or more over the medically recommended weight in the most recent Metropolitan Life Insurance Company tables for a person of the same height, age and mobility as the Covered Person, or having a BMI (body mass index) of 40 or higher, or having a BMI of 35 in conjunction with any of the co-morbidities: coronary artery disease, type II diabetes, clinically significant obstructive sleep apnea or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal Medical Management).

Negotiated Rate – The Hospital rate and Physician fee schedule the Network Providers have contracted to accept as payment in full for Covered Charges of the Plan.

Network/Network Provider Organization – An organization that selects and contracts with certain Hospitals, Physicians, and other healthcare Providers to provide services, supplies and treatment to Covered Persons at a Negotiated Rate. The Network Provider Organizations are IU Health Plans Network, Encircle/Encore Combined Networks, and PHCS Healthy Directions Network.

Network Provider – A Physician, Hospital or ancillary service Provider that has an agreement in effect with the Network Provider Organization to accept a reduced rate for Covered Services rendered to Covered Persons. Network Providers agree to accept the Negotiated Rate as payment in full.

Non-Network Provider – A Physician, Hospital, or other healthcare Provider that does not have an agreement in effect with the Network Provider Organization at the time services are rendered. A Provider not Participating with IU Health Plans, Encircle/Encore Combined Network or PHCS Healthy Directions.

Nurse – A licensed person holding the degree registered Nurse (R.N.), licensed practical Nurse (L.P.N.) or licensed vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Outpatient – A Covered Person shall be considered to be an Outpatient if treated at:

1. A Hospital as other than an Inpatient;
2. A Physician's office, laboratory or x-ray Facility; or
3. An Ambulatory Surgical Facility; and

Out-of-Pocket Maximum – The accrued value of Coinsurance payments that has to be satisfied before Plan reimbursement for Covered Services will be provided in full.

Out-of-State Resident - A Covered Persons living and working outside the State of Indiana where an IU Health Plans Network is not available. (Example: Arizona, Florida, Colorado etc.)

Participating – The status of a Physician or other healthcare Provider that has an agreement to provide healthcare services to Covered Persons of the Plan and accept the Allowed Amount as payment in full.

Participating Pharmacy – Any pharmacy licensed to dispense Prescription Drugs, which is contracted with the pharmacy program offered through the Plan.

Part-time – Team Members regularly scheduled to work less than 48 hours per pay period.

Pervasive Development Disorders (PDD) – refers to a group of conditions that involve delays, absence or regression of special skills, most notably the ability to socialize with others, to communicate, and to use imagination. Children with these conditions often are confused in their thinking and generally have problems understanding the world around them. There are five types of PDD based on how severe are the symptoms and associated symptoms. The five different types are Autism, Asperger's syndrome, childhood disintegrative disorder, Rett's syndrome and Pervasive Development Disorder not otherwise specified.

Physician – A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is practicing within the scope of his license.

Plan – Refers to the Covered Services and provisions for payment of MSD of Wayne Township Employee Benefits Plan.

Plan Administrator – The Plan Administrator is responsible for the overall operations of the Plan and contracts with other entities for day-to-day management of the Plan. The Plan Administrator is the Employer, MSD of Wayne Township.

Post-service Claim – Those claims for which services have already been received (claims other than pre-service claims).

Precertification/Prior Authorization – The process of obtaining approval from Medical Management or Pharmacy Benefits to proceed with receiving a healthcare service or Prescription that is Medically Necessary. Applies to services that are limited or excluded from coverage.

Prescription Drug (Federal Legend Drug) – Any medication which by federal or state law may not be dispensed without a prescription order.

Formulary (Listing of covered drugs and criteria (i.e. Quantity limits, Prior Authorization criteria, or other established criteria) required for coverage. *For a complete listing of formulary medications, please refer to iuhealthplans.org.*

Prescription Quantity Limit – The maximum quantity of specified medications and medication strengths that can be dispensed over a defined days supply.

Primary Care Physician (PCP) – Physicians expert in providing diagnosis and treatment of Illness and provision of preventive care; they also serve as coordinators of the overall care of their patients. A PCP is a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is a general or family practitioner, pediatrician, Mental Health Provider or general internist.

Provider/Professional Provider – A person or organization responsible for furnishing healthcare services, licensed where required and operating within the scope of the license to provide Covered Services to Plan Covered Persons. Providers include, but are not limited to:

- Audiologist
- Certified Addictions Counselor
- Certified Registered Nurse Anesthetist
- Certified Registered Nurse Practitioner
- Chiropractor
- Clinical Laboratory
- Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
- Dentist
- Dietician
- Dispensing optician
- Midwife

- Nurse (R.N., L.P.N., and L.V.N.)
- Nurse Practitioner
- Occupational Therapist
- Optician
- Optometrist
- Physical Therapist
- Physician
- Physician's Assistant
- Podiatrist
- Psychologist
- Respiratory Therapist
- Speech Therapist

Registration – Process of verifying patient information including name, current address, phone number, benefit Plan, and group number. The Registration process must be completed each time you receive healthcare services.

Residential Treatment - Psychiatry health care provided at a live-in facility to a person with emotional disorders that requires continuous medication and/or supervision or relief from environmental stresses.

Retiree – A former Team Member who retired from service of the Employer and has met the Plan's eligibility requirements to continue coverage under the Plan as a Retiree. Unless otherwise indicated, as used in this document, the term Team Member shall include Retirees covered under the Plan.

Retrospective Review – A review by the Medical Management Department after the Covered Person's discharge from a Hospital to determine if, and to what extent, Inpatient care was Medically Necessary.

Room and Board – Room and linen service, dietary service, including meals, Medically Necessary special diets and nourishments, and general nursing services. Room and Board does not include personal items.

Specialists/Specialty Care Providers – Physician practices with expertise in a specific medical specialty or sub-specialty.

Semi-Private – The daily Room and Board charge which a Facility applies to the greatest number of beds in its Semi-Private rooms containing two or more beds.

Subscriber – The Team Member who meets eligibility requirements for enrollment in the Plan, whose healthcare coverage is in effect and whose name appears on the Identification (ID)Card.

Surgery –

- The performance of generally accepted operative and other invasive procedures;
- The treatment of fractures and dislocations;
- Usual and related preoperative and postoperative care; or

- Other procedures as reasonable and approved by the Plan.

Treatment Center –

1. An institution which does not qualify as a Hospital, but which does provide a program of effective medical and therapeutic treatment for Chemical Dependency or Mental Health Disorders, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or
3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the Physician.
    c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the Covered Person.
    d. It provides at least the following basic services:
        i. Room and Board
        ii. Evaluation and diagnosis
        iii. Counseling
        iv. Referral and orientation to specialized community resources.

Urgent Care – Care received for medical conditions that are unforeseen and require attention within 24 hours. Examples of Urgent Care include, but are not limited to:

1. Minor cuts/lacerations
2. Minor burns
3. Minor trauma
4. Seemingly minor Illnesses that include a high fever
5. Sprains

Utilization Review – See Medical Management.