



# UNIVERSITY OF NOTRE DAME

## MEDICAL/DENTAL/VISION PLAN SUMMARY 2007

## MEDICAL/DENTAL/VISION PLAN SUMMARY - 2007

To help you make informed decisions about your insurance election, the University has prepared this 2007 Medical/Dental/Vision Plan Summary. This summary is intended to help you learn more about the benefit plans available to you. It does not replace the legal plan documents or contracts for each of the benefit plans and should not, in any way, be considered a legal contract or guarantee of coverage.

You are responsible for notifying the Office of Human Resources within 31 days of a qualifying life event, such as marriage, childbirth, adoption, and loss or gain of other insurance coverage. **(If you do not apply for additional coverage due to a status change within 31 days of the event, you may not make the change until the next Open Enrollment Period.)**

### IMPORTANT CONTACT INFORMATION

<b>Medical</b>	<b>Meritain Select HMO:</b> Member Service		
	<ul style="list-style-type: none"> <li>• Eligibility, benefit coverage, pre-certification, claim questions</li> </ul>	<a href="http://www.meritain.com">www.meritain.com</a>	1-888-668-6855
	<ul style="list-style-type: none"> <li>• Select Health Network (Local Network)</li> </ul>	<a href="http://www.selecthealthnetwork.com">www.selecthealthnetwork.com</a>	1-888-668-6855
	<ul style="list-style-type: none"> <li>• New Avenues Midwest Behavioral Health Network (mental health provider)</li> </ul>	<a href="http://www.newavenuesonline.com">www.newavenuesonline.com</a>	1-800-223-6246
	<b>Meritain PPO:</b>		
	<ul style="list-style-type: none"> <li>• Eligibility, benefit coverage, pre-certification, claim questions</li> </ul>	<a href="http://www.meritain.com">www.meritain.com</a>	1-888-668-6855
	<ul style="list-style-type: none"> <li>• Select Health Network (Local Network)</li> </ul>	<a href="http://www.selecthealthnetwork.com">www.selecthealthnetwork.com</a>	1-888-668-6855
	<ul style="list-style-type: none"> <li>• Beech Street (National Network)</li> </ul>	<a href="http://www.beechstreet.com">www.beechstreet.com</a>	1-800-432-1776
	<ul style="list-style-type: none"> <li>• New Avenues Midwest Behavioral Health Network (mental health provider)</li> </ul>	<a href="http://www.newavenuesonline.com">www.newavenuesonline.com</a>	1-800-223-6246
	<b>Meritain HMO CHA:</b>		1-888-668-6855
	<ul style="list-style-type: none"> <li>• Eligibility, benefit coverage, pre-certification, claim questions</li> </ul>	<a href="http://www.meritain.com">www.meritain.com</a>	
	<ul style="list-style-type: none"> <li>• Community Health Alliance (CHA) Network</li> </ul>	<a href="http://www.chanetwork.com">www.chanetwork.com</a>	1-888-689-2242 or 1-574-284-1820
<b>Prescription</b>	<b>Medco</b>		
	<ul style="list-style-type: none"> <li>• Benefit coverage, claim questions</li> </ul>	<a href="http://www.medco.com">www.medco.com</a>	1-800-711-0917

<b>Dental</b>	<b>Delta Premier PPO</b>	<a href="http://www.deltadental.com">www.deltadental.com</a>	<b>1-800-524-0149</b>
	<b>Delta Preferred POS</b>	<a href="http://www.deltadental.com">www.deltadental.com</a>	<b>1-888-455-5141</b>
<b>Vision</b>	<b>EyeMed</b>	<a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a> <a href="http://www.enrollwiththeyemed.com">www.enrollwiththeyemed.com</a>	<b>1-866-939-3633</b>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO																					
<b>General Information</b>	Under Meritain PPO, you must call Meritain at the toll-free number, 1-888-668-6855 (on the back of your ID card) before you or a covered family member is admitted to the hospital. Your admission and length of your hospital stay will be reviewed, and if approved, you'll receive benefits based on whether you receive care from a network provider or non-network provider. Lists of Network physicians and hospitals are available at <a href="http://www.selecthealthnetwork.com">www.selecthealthnetwork.com</a> (Local Network) or <a href="http://www.beechstreet.com">www.beechstreet.com</a> (National Network). In the case of a life-threatening emergency, notification to the toll-free number, 1-888-668-6855, must be initiated within 48 hours or the first business day following hospital admission. <b>If a call is not made, a reduced benefit may be paid.</b>	Services are provided by physicians associated with the HMO. To be eligible, a person (and dependents) must reside or work in the HMO's service area. The Health Plan does not require a referral for Specialist Care within the network. Lists of Network physicians and hospitals are available at <a href="http://www.selecthealthnetwork.com">www.selecthealthnetwork.com</a> or by calling 1-888-668-6855.	Services are provided by physicians associated with the HMO. To be eligible, a person (and dependents) must reside or work in the HMO's service area. The Health Plan does not require a referral for Specialist Care within the network. Lists of Network physicians and hospitals are available at <a href="http://www.chanetwork.com">www.chanetwork.com</a> or by calling (574) 284-1820 or 1-888-689-2242.																					
<b>Monthly Premiums</b> <i>(full-time Faculty, Administrators and Staff)</i>	<table> <tr> <td>Individual</td> <td>\$ 52.00</td> </tr> <tr> <td>Individual + 1</td> <td>\$ 182.00</td> </tr> <tr> <td>Family</td> <td>\$ 202.00</td> </tr> </table>	Individual	\$ 52.00	Individual + 1	\$ 182.00	Family	\$ 202.00	<table> <tr> <td>Individual</td> <td>\$ 30.00</td> </tr> <tr> <td>Individual + 1</td> <td>\$ 117.00</td> </tr> <tr> <td>Family</td> <td>\$ 126.00</td> </tr> </table>	Individual	\$ 30.00	Individual + 1	\$ 117.00	Family	\$ 126.00	<table> <tr> <td>Individual</td> <td>\$ 40.00</td> </tr> <tr> <td>Individual + 1</td> <td>\$ 151.00</td> </tr> <tr> <td>Family</td> <td>\$ 163.00</td> </tr> </table>	Individual	\$ 40.00	Individual + 1	\$ 151.00	Family	\$ 163.00			
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<b>Deductibles</b>	<table> <tr> <td></td> <td><u>Individual</u></td> <td><u>Family</u></td> </tr> <tr> <td><u>In-Network</u></td> <td>\$400</td> <td>\$800</td> </tr> <tr> <td><u>Out-of-Network</u></td> <td>\$800</td> <td>\$1600</td> </tr> </table> <p>(Do not cross accumulate between in-network and out-of-network)</p>		<u>Individual</u>	<u>Family</u>	<u>In-Network</u>	\$400	\$800	<u>Out-of-Network</u>	\$800	\$1600	<p><b><u>For In-patient Hospital Services Only</u></b></p> <table> <tr> <td></td> <td><u>Individual</u></td> <td><u>Family</u></td> </tr> <tr> <td><u>In-Network</u></td> <td>\$350</td> <td>\$700</td> </tr> </table>		<u>Individual</u>	<u>Family</u>	<u>In-Network</u>	\$350	\$700	<p><b><u>For In-patient Hospital Services Only</u></b></p> <table> <tr> <td></td> <td><u>Individual</u></td> <td><u>Family</u></td> </tr> <tr> <td><u>In-Network</u></td> <td>\$350</td> <td>\$700</td> </tr> </table>		<u>Individual</u>	<u>Family</u>	<u>In-Network</u>	\$350	\$700
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PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO																					
<b>Co-insurance</b>	<p><b><u>In-Network:</u></b> After your meet your annual deductible, the plan pays 85% of eligible charges and you pay the remaining 15%.</p> <p><b><u>Out-of-Network:</u></b> After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges and you pay the remaining 35% plus any amounts above reasonable &amp; customary.</p>	<p><b><u>For In-patient Hospital Services Only</u></b> After your meet your annual deductible, the plan pays 85% of eligible charges and you pay the remaining 15%.</p>	<p><b><u>For In-patient Hospital Services Only</u></b> After your meet your annual deductible, the plan pays 85% of eligible charges and you pay the remaining 15%.</p>																					
<p><b>Out-of-pocket limits</b> Includes the annual deductible. (Note: Once the out-of-pocket limit is met on an annual basis, the plan pays 100% of eligible charges. No one family member may meet this limit for the whole family.)</p>	<table border="0"> <tr> <td></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td><b><u>In-Network</u></b></td> <td style="text-align: center;">\$1,250</td> <td style="text-align: center;">\$3,000</td> </tr> <tr> <td><b><u>Out-of-Network</u></b></td> <td style="text-align: center;">\$2,500</td> <td style="text-align: center;">\$5,000</td> </tr> </table>		<u>Individual</u>	<u>Family</u>	<b><u>In-Network</u></b>	\$1,250	\$3,000	<b><u>Out-of-Network</u></b>	\$2,500	\$5,000	<p><b><u>For In-patient Hospital Services Only</u></b></p> <table border="0"> <tr> <td></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td><b><u>In-Network</u></b></td> <td style="text-align: center;">\$800</td> <td style="text-align: center;">\$1,600</td> </tr> </table>		<u>Individual</u>	<u>Family</u>	<b><u>In-Network</u></b>	\$800	\$1,600	<p><b><u>For In-patient Hospital Services Only</u></b></p> <table border="0"> <tr> <td></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td><b><u>In-Network</u></b></td> <td style="text-align: center;">\$800</td> <td style="text-align: center;">\$1,600</td> </tr> </table>		<u>Individual</u>	<u>Family</u>	<b><u>In-Network</u></b>	\$800	\$1,600
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<p><b>Physician Office Visits</b> <i>(Co-payments)</i></p>	<p><b><u>In-Network:</u></b> \$20 physician co-payment per office visit (after the co-payment is made, the plan pays 100%). This \$20.00 co-payment is still required even after deductible is met.</p> <p><b><u>Out-of-Network:</u></b> Subject to annual deductible. After you meet your annual deductible, the plan pays 65% of eligible, reasonable, and customary charges and you pay the remaining 35% plus any amounts above reasonable &amp; customary.</p>	<p><b><u>Primary Care Physician – In-Network</u></b> 100% after \$20 co-payment per primary care physician office visit. (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.)</p> <p><b><u>Specialist Physician – In-Network</u></b> 100% after \$30 co-payment per specialist physician office visit within the network.</p>	<p><b><u>Primary Care Physician – In-Network</u></b> 100% after \$20 co-payment per primary care physician office visit. (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.)</p> <p><b><u>Specialist Physician – In-Network</u></b> 100% after \$30 co-payment per specialist physician office visit within the network.</p>																					
<p><b>Physician Hospital Visits</b></p>	<table border="0"> <tr> <td><b><u>In-Network:</u></b></td> <td style="text-align: center;">85%</td> </tr> <tr> <td><b><u>Out-of-Network:</u></b></td> <td style="text-align: center;">65%</td> </tr> </table> <p>After annual deductible is met.</p>	<b><u>In-Network:</u></b>	85%	<b><u>Out-of-Network:</u></b>	65%	<p><b><u>For In-patient Hospital Services Only</u></b></p> <table border="0"> <tr> <td><b><u>In-Network:</u></b></td> <td style="text-align: center;">85%</td> </tr> </table> <p>After annual deductible is met.</p>	<b><u>In-Network:</u></b>	85%	<p><b><u>For In-patient Hospital Services Only</u></b></p> <table border="0"> <tr> <td><b><u>In-Network:</u></b></td> <td style="text-align: center;">85%</td> </tr> </table> <p>After annual deductible is met.</p>	<b><u>In-Network:</u></b>	85%													
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<b>Ambulance</b>	85% after deductible	No charge for service (from area first disabled) to nearest facility qualified to provide care when medically necessary and approved by the Plan.	No charge for service (from area first disabled) to nearest facility qualified to provide care when medically necessary and approved by the Plan.
<b>Anesthesiology, Cardiac and Intensive Care</b>	<b><u>In-Network:</u></b> 85% <b><u>Out-of-Network:</u></b> 65%  After annual deductible is met.	<b><u>For In-patient Hospital Services Only</u></b> <b><u>In-Network:</u></b> 85%  After annual deductible is met.	<b><u>For In-patient Hospital Services Only</u></b> <b><u>In-Network:</u></b> 85%  After annual deductible is met.
<b>Cardiac Rehabilitation</b>	<b><u>In-Network:</u></b> 85% <b><u>Out-of-Network:</u></b> 65%  After annual deductible is met.	\$30 specialist co-payment per office visit. 36 visits per year	\$30 specialist co-payment per office visit. 36 visits per year.
<b>Children Eligibility</b> <i>(Due to age)</i>	Children are eligible until they reach age 23 as long as they remain unmarried and eligible on an employees' tax return.  Coverage ends at December 31 of calendar year in which they turn 23.	Children are eligible until they reach age 19 and are dependent on employee for at least 50% of financial support. If the children are full-time students (at least 12 credit hours) and unmarried, they may remain covered until they reach age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.	Children are eligible until they reach age 19 and are dependent on employee for at least 50% of financial support. If the children are full-time students (at least 12 credit hours) and unmarried, they may remain covered until they reach age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.
<b>Coordination of Benefits</b> <i>(C.O.B.)</i>	Meritain is primary for you (the employee), and your spouse's employer's insurance plan is primary for him or her. The two plans "coordinate" benefits for your dependent children. The "birthday rule" determines which plan is primary (pays first) for your dependent children. For example, if the month and day your birthday falls during the year is <u>before</u> your spouse's birthday, Meritain will be primary and pay benefits first for your dependents.  There are very specific rules about how	Meritain is always primary for you (the employee), and your spouse's employer's insurance plan is always primary for him or her. The two plans "coordinate" benefits for your dependent children. The "birthday rule" determines which plan is primary (pays first) for your dependent children. For example, if the month and day your birthday falls during the year is <u>before</u> your spouse's birthday, Meritain will be primary and pay benefits first for your dependents.  If another plan is primary, Meritain will	Meritain is primary for you (the employee), and your spouse's employer's insurance plan is primary for him or her. The two plans "coordinate" benefits for your dependent children. The "birthday rule" determines which plan is primary (pays first) for your dependent children. For example, if the month and day your birthday falls during the year is <u>before</u> your spouse's birthday, Meritain will be primary and pay benefits first for your dependents.  If another plan is primary, Meritain will

	insurance plans coordinate in situations such as legal separation or divorce. In these situations, the Office of Human Resources should be contacted.	consider the remaining eligible charges. Meritain would coordinate for any service within their network.	consider the remaining eligible charges. Meritain would coordinate for any service within their network.
<b>PLAN COVERAGE</b>	<b>MERITAIN PPO</b>	<b>MERITAIN SELECT HMO</b>	<b>MERITAIN CHA HMO</b>
<b>Diabetic Supplies</b> Part of the Pharmacy Benefit.	Not Applicable	Not Applicable	Not Applicable
<b>Durable Medical Equipment</b>	<p><b><u>In-Network</u></b> After deductible, plan pays 85% of eligible charges up to annual maximum.</p> <p><b><u>Out-of-Network</u></b> After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges up to the annual maximum.</p> <p>Annual maximum of \$15,000 per person / per year.</p>	Covered in full with prior approval from Meritain Health.	Covered in full with prior approval from Meritain Health.
<b>Emergency Services</b> <i>(Out-of-Area/Out-of-State)</i>	You are not required to contact Meritain before seeking medical treatment. If a network provider is used, benefits are paid at 85% after deductible. If an out-of-network provider is used, benefits are paid at 65% of U&C (usual and customary) after deductible. If you are out of the area at the time emergency treatment is required, and it is not life threatening, you may call Beech Street at 1-800-432-1776 to locate the nearest national network provider. If the medical emergency turns into an inpatient hospital admission, the physician or the employee should contact Meritain within 48 hours to have the stay pre-certified.	<p>If you have a medical emergency and your medical condition is dangerous or life threatening, you should go to the nearest medical facility for treatment (whether you are in the service area or out of the area).</p> <p>Contact Meritain Health to notify them of the emergency treatment.</p> <p>\$120 co-payment for Emergency Room</p> <p>Routine medical care and non-emergency care received out of town is not covered.</p>	<p>If you have a medical emergency and your medical condition is dangerous or life threatening, you should go to the nearest medical facility for treatment (whether you are in the service area or out of the area).</p> <p>Contact Meritain Health to notify them of the emergency treatment.</p> <p>\$120 co-payment for Emergency Room</p> <p>Routine medical care and non-emergency care received out of town is not covered.</p>
<b>Emergency Services</b> <i>(In-Area)</i>	<p><b><u>Network:</u></b> 85%</p> <p><b><u>Out-of-Network:</u></b> 65%</p> <p>After annual deductible is met.</p> <p><b><u>Urgent Care</u></b></p>	<p>\$120 co-payment for Emergency Room (waived if patient is admitted).</p> <p><b><u>Urgent Care</u></b></p>	<p>\$120 co-payment for Emergency Room (waived if patient is admitted).</p> <p><b><u>Urgent Care</u></b> \$40 co-payment for Urgent Care Facility at MedPoint and other CHA Urgent Care</p>

	\$50 co-payment for services provided at Urgent Care Center.	\$40 co-payment for services provided at Urgent Care Center.	providers. \$25 co-pay for urgent care at Medpoint Express.
<b>PLAN COVERAGE</b>	<b>MERITAIN PPO</b>	<b>MERITAIN SELECT HMO</b>	<b>MERITAIN CHA HMO</b>
<b>Fertility Testing and Counseling</b>	<p><b>Network:</b> 85%</p> <p><b>Out-of-Network:</b> 65%</p> <p>After annual deductible is met.</p> <p>Provides coverage for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.</p>	<p>\$20 co-payment per primary care physician office visit for Out-Patient charges.</p> <p>\$30 co-pay per office visit for specialist</p> <p>\$350 hospital co-payment for In-Patient stays</p> <p>\$100 co-payment for out-patient surgery.</p> <p>Provides coverage for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.</p>	<p>\$20 co-payment per office visit for Out-Patient charges from a PCP.</p> <p>\$30 co-pay per office visit for specialist</p> <p>\$350 hospital co-payment for In-Patient stays.</p> <p>\$100 co-payment for out-patient surgery.</p> <p>Provides coverage for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.</p>
<b>Home Health Care</b>	<p><b>Network:</b> 85%</p> <p><b>Out-of-Network:</b> 65%</p> <p>After annual deductible is met and if determined to be medically necessary. Subject to \$25,000 annual maximum/\$50,000 lifetime maximum. There may be some limitations.</p>	100% after \$20 co-payment per visit. Limit of 60 visits per Calendar Year.	100% after \$20 co-payment per visit. Limit of 60 visits per Calendar Year.
<b>Hospital Room &amp; Board</b>	<p><b>Network:</b> 85%</p> <p><b>Out-of-Network:</b> 65%</p> <p>After annual deductible is met.</p>	After your meet your annual deductible, the plan pays 85% of eligible charges and you pay the remaining 15%.	After your meet your annual deductible, the plan pays 85% of eligible charges and you pay the remaining 15%.
<b>Human Organ Transplants</b>	Meritain utilizes Life Trac as their program for transplants and other services. Life Trac program offers over 30 hospitals across the US including, Chicago Medical Center, University of Michigan Medical Center, Memorial Sloan-Kettering Cancer Center, and MD Anderson.	Meritain utilizes Life Trac as their program for transplants and other services. Life Trac program offers over 30 hospitals across the US including, Chicago Medical Center, University of Michigan Medical Center, Memorial Sloan-Kettering Cancer Center, and MD Anderson.	Meritain utilizes Life Trac as their program for transplants and other services. Life Trac program offers over 30 hospitals across the US including, Chicago Medical Center, University of Michigan Medical Center, Memorial Sloan-Kettering Cancer Center, and MD Anderson.

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<b>Hospitals</b>	<ul style="list-style-type: none"> <li>• St. Joseph Community Hospital, Mishawaka, IN;</li> <li>• St. Joseph Regional Medical Center, Plymouth, IN;</li> <li>• St. Joseph's Regional Medical Center, South Bend, IN;</li> <li>• Memorial Hospital Mother and Child Care Center and neo-natal nursery are included as in-network services.</li> <li>• Community Hospital of Bremen, Bremen, IN</li> <li>• Goshen General Hospital, Goshen, IN</li> <li>• Indiana University Medical Center, Indianapolis, IN</li> <li>• Lakeland Regional Medical Center, Niles, MI</li> <li>• La Porte Hospital, La Porte, IN</li> <li>• Methodist Hospital, Indianapolis, IN</li> <li>• Riley Children's Hospital, Indianapolis, IN</li> <li>• Saint Anthony Hospital, Michigan City, IN</li> <li>• South Haven Community Hospital, South Haven, MI</li> </ul> <p>(See directory or web page for a complete listing.)</p>	<ul style="list-style-type: none"> <li>• St. Joseph Community Hospital, Mishawaka, IN;</li> <li>• St. Joseph Regional Medical Center, Plymouth, IN;</li> <li>• St. Joseph's Regional Medical Center, South Bend, IN;</li> <li>• Community Hospital of Bremen, Bremen, IN</li> <li>• Goshen General Hospital, Goshen, IN</li> <li>• Indiana University Medical Center, Indianapolis, IN</li> <li>• Lakeland Regional Medical Center, Niles, MI</li> <li>• La Porte Hospital, La Porte, IN</li> <li>• Methodist Hospital, Indianapolis, IN</li> <li>• Riley Children's Hospital, Indianapolis, IN</li> <li>• Saint Anthony Hospital, Michigan City, IN</li> <li>• South Haven Community Hospital, South Haven, MI</li> </ul> <p>(See directory or web page for a complete listing.)</p>	<ul style="list-style-type: none"> <li>• Memorial Hospital, South Bend, IN;</li> <li>• Adams County Memorial Hospital, Decatur, IN;</li> <li>• Bloomington Hospital; Bloomington, IN;</li> <li>• Clarian/I.U. Medical Center, Indianapolis, IN;</li> <li>• Clarian/Riley Hospital for Children, Indianapolis, IN;</li> <li>• Community Hospital of Bremen, Bremen, IN;</li> <li>• Elkhart General Hospital, Elkhart, IN;</li> <li>• LaPorte Hospital, LaPorte, IN;</li> <li>• Madison Hospital, South Bend, IN 46617;</li> <li>• Lakeland Medical Center-Niles, Niles, MI;</li> <li>• Oaklawn Psychiatric Center, Inc., Goshen, IN;</li> <li>• St. Anthony Memorial Health Center, Michigan City, IN;</li> <li>• University of Chicago Hospitals, Chicago, IL;</li> </ul> <p>(See directory or web page for a complete listing.)</p>
<b>Laboratory &amp; X-Ray</b> (Billed by a radiologist, pathologist or hospital)	<p><b><u>Network:</u></b> 85%</p> <p><b><u>Out-of-Network:</u></b> 65%</p> <p>After annual deductible is met.</p>	<p><b><u>For In-patient Hospital Services Only</u></b></p> <p><b><u>In-Network:</u></b> 85%</p> <p>After annual deductible is met.</p> <p><b><u>For Out-patient Services</u></b></p> <p>Eligible charges are covered at 100%</p>	<p><b><u>For In-patient Hospital Services Only</u></b></p> <p><b><u>In-Network:</u></b> 85%</p> <p>After annual deductible is met.</p> <p><b><u>For Out-patient Services</u></b></p> <p>Eligible charges are covered at 100%</p>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p><b>Maternity</b> (No pre-existing conditions apply)</p>	<p><b><u>Network:</u></b> Maternity benefits are administered under a global fee charge at the time of delivery. Global fees include antepartum care (visits to doctor prior to delivery), delivery services (vaginal delivery --- with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visit following delivery). Because of the global fee, the \$20 co-payment may not be required at each office visit. Subject to annual deductible and 85% coinsurance. Memorial Hospital Mother and Child Care Center and neo-natal nursery are included as in-network services. Baby Steps is a program offered by Meritain that offer case management to High-risk pregnancies.</p> <p><b><u>Out-of-Network:</u></b> Pre-natal and post-natal office visits and delivery---subject to annual deductible and 65% coinsurance. Baby needs to be enrolled within 31 days of birth.</p>	<p><b>100% after \$20 co-payment per office visit. 100% after \$30 specialist co-pay per office visit.</b></p> <p>Delivery fee: 85% after inpatient deductible. A single hospital deductible-payment applies for mother and child providing mother and child are discharged at the same time.</p> <p>Maternity benefits are administered under a global fee charge at the time of delivery, including ante-partum care (doctor visits prior to delivery), delivery services (vaginal delivery – with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visits following delivery).</p> <p>Baby Steps is a program offered by Meritain that offer case management to High-risk pregnancies. Baby needs to be enrolled within 31 days of birth.</p>	<p><b>100% after \$20 co-payment per office visit. 100% after \$30 specialist co-pay per office visit.</b></p> <p>Delivery fee: 85% after inpatient deductible. A single hospital deductible-payment applies for mother and child providing mother and child are discharged at the same time.</p> <p>Maternity benefits are administered under a global fee charge at the time of delivery, including ante-partum care (doctor visits prior to delivery), delivery services (vaginal delivery – with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visits following delivery).</p> <p>Baby Steps is a program offered by Meritain that offer case management to High-risk pregnancies. Baby needs to be enrolled within 31 days of birth.</p>
<p><b>Mental Health Services</b> (In-patient)</p> <p>A Meritain Clinical Case Manager will determine medical necessity and duration in collaboration with your therapist.</p>	<p><b><u>In-Network:</u></b> 85% after annual deductible is met for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. Limited to 60 days per calendar year (less in-patient alcoholism/drug abuse days used).</p> <p><b><u>Out-of-Network:</u></b> 65% after annual deductible is met for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. Limited to 60 days per calendar year (less in-patient alcoholism/drug abuse days used).</p>	<p><b><u>In-Network:</u></b> 85% after annual deductible is met for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. Limited to 60 days per calendar year (less in-patient alcoholism/drug abuse days used).</p>	<p><b><u>In-Network:</u></b> 85% after annual deductible is met for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. Limited to 60 days per calendar year (less in-patient alcoholism/drug abuse days used).</p>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<b>Mental Health Services</b> <i>(Out-patient)</i>	<p><b><u>In-Network:</u></b>  85% after annual deductible is met for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. (Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment. Limited to 50 visits per calendar year. (less out-patient alcoholism/drug abuse visits used).</p> <p><b><u>Out-of-Network:</u></b>  65% after annual deductible is met for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. Limited to 50 visits per calendar year. (Less out-patient alcoholism/drug abuse visits used).</p>	Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment for physician services (M.D., Ph.D., and Licensed Clinical Social Worker) per office visit. Limited to 20 visits per calendar year per member when medically necessary (less out-patient alcoholism/drug abuse visits used).	Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment for physician services (M.D., Ph.D., and Licensed Clinical Social Worker) per office visit. Limited to 20 visits per calendar year per member when medically necessary (less out-patient alcoholism/drug abuse visits used).
<b>Occupational Therapy</b>	<p><b><u>In-Network:</u></b>  \$20 co-payment per visit.</p> <p><b><u>Out-of-Network:</u></b>  65% After annual deductible is met.</p>	100% after \$20 co-payment per office visit for up to 20 outpatient visits. Inpatient short-term rehabilitation covered for 60 consecutive days. Long-term rehabilitation is <b>not</b> covered.	100% after \$20 co-payment per office visit for up to 20 outpatient visits. Inpatient short-term rehabilitation covered for 60 consecutive days. Long-term rehabilitation is <b>not</b> covered.
<b>Physical Therapy</b>	<p><b><u>In-Network:</u></b>  100% after \$20 co-payment per visit.</p> <p><b><u>Out-of-Network:</u></b>  65% after deductible.</p> <p>Treatment plans including frequency and duration are required from the provider.</p>	100% after a \$20 co-payment per office visit for up to 20 out-patient visits. <p>Treatment plans including frequency and duration are required from the provider.</p>	100% after \$20 co-payment per office visit for up to 20 outpatient visits. <p>Treatment plans including frequency and duration are required from the provider.</p>
<b>Orthotic Appliances</b> <i>(such as braces or splints)</i>	<p><b><u>In-Network:</u></b>  85% After deductible, up to annual maximum.</p> <p><b><u>Out-of-Network:</u></b>  65% after annual deductible up to the annual maximum.</p> <p>Annual maximum of \$10,000 per person / per year.</p>	Covered in full. (Some limitations and exclusions apply).	Covered in full. (Some limitations and exclusions apply).

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p><b>Preventive Care –</b></p> <ul style="list-style-type: none"> <li>• Physical Exam</li> <li>• Well Woman Care (including Pap test)</li> <li>• Mammogram</li> <li>• Blood Screening (plus blood pressure/height and weight)</li> <li>• Sigmoidoscopy</li> <li>• Occult blood</li> <li>• Prostate-Specific Antigen (PSA)</li> <li>• Eligible immunizations: DPT, MM, Tuberculin skin test and annual flu shot.</li> </ul>	<p><b>IN-NETWORK ONLY</b></p> <p><b>Participants age 7 and over</b></p> <ul style="list-style-type: none"> <li>• All eligible services are covered at 100%, no co-payment, 1 per year</li> <li>• All eligible services are covered at 100%, no co-payment, 1 per year.</li> <li>• Baseline at age 35; 1 per year after age 40.</li> <li>• 1 per year</li> <li>• 1 per year after age 50.</li> <li>• 1 per year after age 40.</li> <li>• 1 per year after age 50.</li> </ul> <p>18 years of age and older - only applicable to eligible immunizations. (State mandated immunizations are covered at any age.)</p>	<p><b>IN-NETWORK ONLY</b></p> <p><b>No Age Limit</b></p> <ul style="list-style-type: none"> <li>• All eligible services are covered at 100%, no co-payment, 1 per year</li> <li>• All eligible services are covered at 100%, no co-payment, 1 per year.</li> <li>• Baseline at age 35; 1 per year after age 40.</li> <li>• 1 per year</li> <li>• 1 per year after age 50.</li> <li>• 1 per year after age 40.</li> <li>• 1 per year after age 50.</li> </ul> <p>18 years of age and older - only applicable to eligible immunizations. (State mandated immunizations are covered at any age.)</p>	<p><b>IN-NETWORK ONLY</b></p> <p><b>No Age Limit</b></p> <ul style="list-style-type: none"> <li>• All eligible services are covered at 100%, no co-payment, 1 per year</li> <li>• All eligible services are covered at 100%, no co-payment, 1 per year.</li> <li>• Baseline at age 35; 1 per year after age 40.</li> <li>• 1 per year</li> <li>• 1 per year after age 50.</li> <li>• 1 per year after age 40.</li> <li>• 1 per year after age 50.</li> </ul> <p>18 years of age and older - only applicable to eligible immunizations. (State mandated immunizations are covered at any age.)</p>
<p><b>Preventive Care - Children</b></p> <ul style="list-style-type: none"> <li>• Periodic Well Care checkups</li> <li>• Well Baby Care</li> <li>• Immunizations/Inoculations</li> </ul>	<p><b>Under age 7</b></p> <p><b><u>In-Network:</u></b> All eligible services are covered 100%, no co-payment.</p> <p><b><u>Out-of-Network:</u></b> Subject to deductible and 65% coinsurance.</p> <p>(State mandated immunizations are covered at any age.)</p>	<p><b>No age limit</b></p> <p><b>Coverage for In-Network Only</b></p> <p>All eligible services are covered 100%, no co-payment.</p>	<p><b>No age limit</b></p> <p><b>Coverage for In-Network Only</b></p> <p>All eligible services are covered 100%, no co-payment.</p>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p><b>Prosthesis</b></p>	<p><b><u>In-Network:</u></b> After deductible, plan pays 85% of eligible charges up to annual maximum.</p> <p><b><u>Out-of-Network:</u></b> After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges.</p> <p>Annual maximum of \$20,000 per person / per year.</p>	<p>Covered in full with prior approval from Meritain Health.</p>	<p>Covered in full with prior approval from Meritain Health.</p>
<p><b>Skilled Nursing Facility</b></p>	<p><b><u>In-Network:</u></b> 85% <b><u>Out-of-Network:</u></b> 65%</p> <p>After annual deductible is met if medically necessary. No custodial care.</p>	<p>No charge for up to 60 days per calendar year, if medically necessary. No custodial care.</p>	<p>No charge for up to 60 days per calendar year, if medically necessary. No custodial care.</p>
<p><b>Substance Abuse Services</b> <i>(In-patient)</i> <i>Cross-accumulation with mental health.</i></p>	<p><b><u>In-Network:</u></b> 85% <b><u>Out-of-Network:</u></b> 65%</p> <p>After annual deductible is met and if confined in an approved facility. Limit of 60 days per year. Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional (M.D., Ph.D. and Licensed Clinical Social Worker) (Less inpatient mental health services).</p>	<p>Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional (M.D., Ph.D. and Licensed Clinical Social Worker); covers short-term crisis and acute symptoms or impairment stabilization. Covered at 85% after \$350 deductible per admission; limited to 60 days per member per calendar year. (Less Inpatient mental health services).</p>	<p>Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional (M.D., Ph.D. and Licensed Clinical Social Worker); covers short-term crisis and acute symptoms or impairment stabilization. Covered at 85% after \$350 deductible per admission; limited to 60 days per member per calendar year. (Less Inpatient mental health services).</p>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p><b>Substance Abuse Services</b> (Out-patient) Cross-accumulation with mental health.</p>	<p><b><u>In-Network:</u></b> 85% <b><u>Out-of-Network:</u></b> 65%</p> <p>After annual deductible is met for physician (M.D., Ph.D. and Licensed Clinical Social Worker) services. Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment. Limited to 50 visits per year. (Less out-patient mental nervous visits used).</p>	<p>Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment per office visit (M.D., Ph.D. and Licensed Clinical Social Worker.) Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment.</p> <p>Limited to 20 visits per contract year per member when medically necessary (Less out-patient mental nervous visits used).</p>	<p>Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment per office visit (M.D., Ph.D. and Licensed Clinical Social Worker.) Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment.</p> <p>Limited to 20 visits per contract year per member when medically necessary (Less out-patient mental nervous visits used).</p>
<p><b>Surgery / In-patient</b></p>	<p><b><u>Network:</u></b> 85% after deductible. <b><u>Out-of-Network:</u></b> 65% after deductible of eligible, reasonable, and customary charges.</p>	<p>85% after annual in-patient deductible.</p>	<p>85% after annual in-patient deductible.</p>
<p><b>Surgery / Out-patient</b> (office)</p>	<p><b><u>In-Network:</u></b> 85% after deductible. (Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment). <b><u>Out-of-Network:</u></b> 65% after deductible.</p>	<p>100% after \$100 co-payment per procedure for out-patient surgery.</p>	<p>100% after \$100 co-payment per procedure for out-patient surgery.</p>
<p><b>TMJ (Temporomandibular Joint Syndrome)</b></p>	<p>Non-Surgical treatment covered at 85% in-network and 65% UCR out of network, subject to deductible up to \$1000 yearly maximum and \$3000 lifetime maximum.</p> <p>Inpatient and Outpatient Hospitalization (Surgical Benefit) is covered at 85% in network and 65% UCR out of network, subject to deductible.</p>	<p>Not Covered</p>	<p>Not Covered</p>
<p><b>Voluntary Abortion and/or Sterilization</b></p>	<p>Not Covered</p>	<p>Not Covered</p>	<p>Not Covered</p>

# PRESCRIPTION BENEFIT- WITH ALL MEDICAL PLANS

Program Administrated by Medco [www.medco.com](http://www.medco.com)

1-800-771-0917

Three tier program with use of preferred drug listing called a formulary.

	Participating Retail Pharmacy Up to a 30-day supply	Mail Service Up to a 90-day supply
Generic	\$5	\$12
Brand formulary	\$20	\$45
Brand non-formulary	\$35	\$75
Specialty drugs	\$70	\$150 *

\* When clinically appropriate

## What is a formulary?

A formulary is a cost-effective solution to help you with select prescription drugs for your and your family. The formulary is a continually updated list of preferred drugs selected by a panel of physicians and pharmacists. A drug on the formulary benefits members as it gives them access to valuable medications at a lower co-payment. Both generic and brand drugs that provide effective, safe, and appropriate drug therapies are listed on the formulary.

## Generic Drugs versus Brand Name Drugs:

**Generic Drugs** are identical to brand name drugs, but are sold under their chemical generic name. Generic drugs must contain the same active chemical ingredients and be equivalent in strength and dosage from to the brand-name product. The federal Food and Drug Administration regulates the quality, strength and purity of generic drugs.

**Brand-Name** Drugs are drugs that are advertised and sold under a product name chosen by the manufacturer. In general, brand-name drugs are more expensive than generic drugs.

## Mail Service Requirement:

You may receive your first three refills for long-term or maintenance medications under the retail network service. Your fourth and future refills must be obtained through the mail service to avoid higher co-payments. Long-term or maintenance medications filled at retail after the **first three refills** will be subject to **double** the retail co-payments for up to a 30-day supply (\$10 for generic, \$40 for brand, or \$70 for brand non-formulary)

By using the mail service program you can receive up to a 90 day supply of long-term or maintenance medication for two months worth of retail co-payments. Mail service co-payments are as follows: \$20 generic, \$45 brand, or \$75 brand non-formulary.

## Oral Contraceptives:

Drug treatment for correction of existing pathologies of the reproductive system only.

No payment will be made for expenses incurred:

- For oral contraceptive or contraceptive devices, except when specifically requested by a physician based on medical necessity and for purposes other than contraception. Contraceptive implants, such as Norplant, are not considered Covered Prescription Drugs.
- For oral and injectable fertility drugs administered in conjunction with artificial insemination, in-vitro fertilization (IVF), GIFT, ZIFT or any other treatment designed

# VISION PLAN

The University of Notre Dame's Vision care is provided through EyeMed. EyeMed vision care offers savings on eye examinations, contact lenses, lens options and accessories, as well as LASIK and PRK laser vision correction procedures. You may choose independent ophthalmologists, optometrists, opticians, and LensCrafters locations throughout the country. A complete provider listing can be viewed at [www.enrollwithyemed.com](http://www.enrollwithyemed.com). There are no claim forms to complete for in-network services.

Vision Care	Member Cost	Out-of-Network Allowance
<b>Exam with dilation as Necessary (Glasses):</b>	\$0	Up to \$35
<b>Standard Plastic Lenses:</b>		
Single Vision	\$10 co-payment	Up to \$25
Bifocal	\$10 co-payment	Up to \$40
Trifocal	\$10 co-payment	Up to \$55
Lenticular	\$10 co-payment	Up to \$55
<b>Frames:</b>		
Any frame available at provider location	\$0 co-payment, \$130 allowance for any frame plus 20% off balance over \$130	Up to \$45
<b>Lens Options:</b>		
UV Coating	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Scratch-Resistance	\$15	N/A
Standard Polycarbonate	\$40	N/A
Standard Progressive-(add-on to Bifocal)	\$65	N/A
Standard Anti-Reflective	\$45	N/A
Other Add-Ons and Services	20% discount	N/A
<b>Contact Lenses:</b>		
(Includes exam, fit, follow-up, and materials)		
Conventional	\$0 co-payment, plus 15% discount off balance over \$130	Up to \$100
Disposables	\$0 co-payment, plus balance over \$130	Up to \$100
Medically Necessary	\$0 co-payment, plus balance over \$250	Up to \$200
<b>Laser Vision Correction:</b>		
Lasik or PRK From US Laser Network	15% of retail price or 5% off promotional price	N/A
<b>Frequency:</b>		
Examination	Once every 12 months	
Frame	Once every 24 months	
Lenses or Contact Lenses	Once every 12 months	
<b>Vision Premiums per month</b>		
Individual	\$8.32	
Individual+1	\$15.72	
Family	\$23.04	

MEMBERS MAY UTILIZE THE FOLLOWING PLAN ONCE THE INITIAL VISION BENEFIT PLAN HAS BEEN EXHAUSTED.

**Premier-Plus Secondary Purchase Discount**

<b>Vision Care Services</b>	<b>Member Cost</b>
<b>Exam with dilation as Necessary (glasses):</b>	\$5 off routine exam
<b>Standard Plastic Lenses*:</b> Single Vision Bifocal Trifocal Lenticular *Member cost is \$15 higher in AK, CA, HI, OR, WA	\$35 Co-payment \$55 Co-Payment \$90 Co-Payment \$90 Co-Payment
<b>Frames:</b> Any frame available at provider location	45% off retail price up to \$130 plus 20% off balance over \$130
<b>Lenses Options:</b> UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Polycarbonate Standard Progressive-(add-on to Bifocal) Standard Anti-Reflective Other Add-Ons and Services	\$12 \$12 \$15 \$35 \$45 \$45 20% discount
<b>Contact Lenses:</b> Discount applied to materials only) Conventional	15% off retail price
<b>Laser Vision Correction:</b> Lasik or PRK From US Laser Network	15% off retail price – or 5% off promotional price
<b>Frequency:</b> Examination Frame Lenses Contact Lenses	Unlimited Unlimited Unlimited Unlimited

\*The cost for Premium Progressive lenses equals the Basic Progressive lens retail price plus a 20% discount on the balance over this price.

**Member will receive a 20% discount on remaining balance at participating providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed’s Providers professional services, or disposable contact lenses.**

Plan Limitations/Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment
- Services provided as a result of any Worker’s Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state, or subdivisions thereof.
- Plan non-prescription lenses and non-prescription sunglasses (except for 20% discount)
- Services or materials provided by any other group benefit providing for vision care

# DENTAL PLANS

PLAN COVERAGE	Delta Premier PPO			Delta Preferred POS				
Network	Offices available in South Bend, Granger, Elkhart, Mishawaka, and more. See <a href="http://www.ddpin.com">www.ddpin.com</a> for details on locations. Delta also offers a benefit for out-of-network services.			Offices available in South Bend, Granger, Elkhart, Mishawaka, and more. See <a href="http://www.ddpin.com">www.ddpin.com</a> for details on locations. . Delta also offers a benefit for out-of-network services.				
	Participating Dentist Plan Pays Delta Premier		Non-Participating Dentist Plan Pays	Participating Dentist Plan Pays Delta Preferred		Delta Premier & Non- Participating Dentist Plan Pays		
Deductibles	\$50 for basic and major services, limit of \$150 per family			\$50 for basic and major services, limit of \$150 per family				
Diagnostic & Preventive Procedures	100%		100% of Usual & Customary	100%		100% of Usual & Customary		
Basic Services	50% (after deductible)		50% of Usual & Customary (after deductible)	80% (after deductible)		50% of Usual & Customary		
Major Services	50% (after deductible)		50% of Usual & Customary (after deductible)	50% (after deductible)		50% of Usual & Customary (after deductible)		
Annual Benefit	\$1,000 per person per year			\$1,500 per person per year				
Orthodontics	50% Maximum lifetime benefit of \$1,000			50% Maximum lifetime benefit of \$1,000				
Children Eligibility (due to age)	Children are eligible up to the age of 19. If they are a full-time student they may be covered up to the age of 25. If a child loses eligibility their coverage will terminate the end of the calendar month in which they lose eligibility. You will be required to provide proof of full-time status to the insurance company before any claims are paid.							
Dental Premiums per month	2007 Individual	\$15.42	2008 Individual	\$17.06	2007 Individual	\$20.38	2008 Individual	\$22.32
	Individual+1	\$30.56	Individual+1	\$33.48	Individual+1	\$41.60	Individual+1	\$45.22
	Family	\$68.00	Family	\$73.32	Family	\$86.88	Family	\$93.42

*\* If enrolling a 2-year commitment is required.*