MSD OF WAYNE TOWNSHIP EMPLOYEE BENEFIT PLAN

SUPPLEMENTAL RENAL DIALYSIS BENEFIT BOOKLET

EFFECTIVE JANUARY 1, 2019

MSD of Wayne Township (Wayne) provides group health care benefits (including outpatient renal dialysis services) to its employees and dependents through the MSD of Wayne Township Employee Benefit Plan (the Plan). The 2019 amended Summary Plan Description (SPD) for the Plan has previously been provided to you as a participant in this Plan.

This Supplemental Renal Dialysis Benefit Booklet provides additional information pertaining to certain changes affecting the outpatient renal dialysis services that are provided under the Plan. These benefits are covered by the Plan, and no additional premiums are required for these benefits.

Please note that general information regarding the Plan, including your rights under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), can be found in the Summary Plan Description previously provided.

Effective Date of Changes

These changes are effective January 1, 2019.

Outpatient Renal Dialysis Services

Charges for the member's first 40 renal dialysis visits, cumulative and not subject to annual reset, are a Covered Service only up to 70% of the allowable amount for Out-of-Network providers and 100% for In Network providers. Charges that exceed this amount are not a Covered Service and are not eligible for reimbursement under the Plan. Visits for both network providers and non-network providers are a Covered Service and eligible for reimbursement under the Plan during the member's first 40 visits, subject to the limitations described above.

The Plan does not utilize or access any network for additional visits beyond the first 40 renal dialysis visits. Charges for additional visits are a Covered Service only up to 150% of the national Medicare allowable amount, adjusted for the geographic wage index. Charges that exceed this amount are not a Covered Service and are not eligible for reimbursement under the Plan. Benefits are paid at 100% of the allowable, with no deductible, for all visits beyond the first 40 renal dialysis visits.

Coordination of Benefits

Medicare Part B Reimbursement: If you or your covered dependent has End-Stage Renal Disease ("ESRD"), the Plan's medical programs primary status applies during the first thirty (30) months of treatment in connection with a transplant. Thereafter, Medicare generally becomes the primary payer of benefits.

The Medicare Secondary Payer statute requires the Plan to identify members in the Plan who are eligible for Medicare, including those based on ESRD and eligible dependents. To insure the correct coordination of claims payments, you are required to provide the Plan the basis for their eligibility to Medicare (age, ESRD, or disability) and the effective date of Medicare Part A and Part B.

During the period where the Plan has primary status, Medicare Part B monthly premiums for covered members and their dependents who have become entitled, including dually entitled, to Medicare based on ESRD will be covered by the Plan. Reimbursement for monies withheld by Medicare from Social Security, Railroad Retirement, or Office of Personnel Management payments will be made at the end of each calendar quarter.

Procedures for Submitting Claims

During the first 40 visits, outpatient dialysis claims are administered by the Plan's primary claims administrator. Please see your Summary Plan Description for claims submission information.

Beyond the first 40 visits, claims for outpatient renal dialysis services must be submitted to Preferred Administrators as follows:

Electronic Claims: Zelis - Preferred Administrators
PMB #418 15560 N FLW Blvd
Scottsdale, AZ 85260
Electronic Payer ID: #88057

Paper Claims: Preferred Administrators
PO Box 18263
Tampa, FL 33679-8263