LEGACY OF LEADERSHIP

2014/2015 Benefits Guide for Andrews University

Table of Contents

Table of Contents 2

Welcome 3

Premier Plan 4-6
ASR Health Benefits – 30 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Standard Plan 7-9
ASR Health Benefits – 30 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

QHDHP Plan 10-12
ASR Health Benefits – 30 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Dental and Vision Plan 13
ASR Health Benefits – 30 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

FSA /Limited Purpose FSA 14-16
ASR Health Benefits – 30 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Wellness 17
Lakeland Care

Basic Life. 18
The Hartford – 35 Hours/AF/SA/SF/FA/FF/FT

Long Term Disability. 19-20
The Hartford - 35 Hours/AF/SA/SF/FA/FF/FT

Travel Assistance & Identity Theft 21
The Hartford – 20 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Estate Guidance 22
The Hartford – 20 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Voluntary Supplemental Life 23-24
The Hartford – 20 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Voluntary Accidental Death 25-26
The Hartford – 20 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Voluntary Short Term Disability 27
Unum – 20 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Voluntary Accident Plan. 28-29
Unum – 20 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Voluntary Critical Illness 30-31
Unum – 20 Hours/AF/AP/SA/SF/SP/FA/FF/FT/FP

Whole Life 32
Unum

Important Information 33-37
Andrews University – All Eligible Employees

Notes 38

Resources 39

The 2014 benefits guide is only a brief summary of your benefits. Andrews University has tried to ensure its accuracy, but if there is any discrepancy between the benefits discussed in this guide and the official plan document, the official plan document will rule. Actual benefits will be paid in accordance with the carrier contracts and any amendments to those contracts in place at the time of the claim. Please refer to your benefit booklets for details regarding your coverage, including benefit limitations and exclusions. Andrews University reserves the right to amend, modify or terminate any plan at any time and in any manner.

Welcome

Welcome to the 2014-2015 Andrews University Benefits Guide. Andrews University employees are its most valuable resource. As such, our employees should know that they are valued. One way to do that is to make sure that, as employees, you understand the value of working at Andrews University.

This guide will walk you through your benefits so that you have a better understanding of how the benefits add value to your AU experience. The AU benefit package is a significant addition to each employee's life both on and off campus. These benefits make a significant difference in the lives of our employees and their families.

It is our hope that each of you will have a better understanding of how each element of the employee benefits plan works together to provide support for you both at work and away from work. Please keep this guide as a handy reference tool to use throughout the year as questions arise regarding any one of your benefits.

It is our hope that a better understanding of your benefits will produce a team more committed to our mission of serving Christ and our passion of educating young people to commit their lives to changing the world.

Premier Plan

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

Benefit Description		
	In-Network	**Out-Of-Network**
Benefit Year	July 1 through June 30	
Deductible per Benefit Year	$400 / person $800 / family	$3,000 / person $6,000 / family
Special Note About the Benefit Year Deductible: Only charges billed by in-network providers will accrue toward the deductible for in-network services, and only charges billed by out-of-network providers will accrue toward the deductible for out-of-network services.		
General Benefit Percentage	90% after deductible (10% coinsurance)	60% after deductible (40% coinsurance)
Coinsurance Maximum Out-Of-Pocket per Benefit Year	$2,850 / person* $5,700 / family*	$5,000 / person* $10,000 / family*
*Only charges billed by in-network providers will accrue toward the Coinsurance Maximum Out-of-Pocket for in-network services, and only charges billed by out-of-network providers will accrue toward the Coinsurance Maximum Out-of-Pocket for out-of-network services.		
Total Maximum Out-Of-Pocket per Benefit Year (Includes Deductible, Coinsurance, and Medical Co-payments Only)	$6,350 / person** $12,700 / family**	Not applicable
**Does not include prescription drug co-payments or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. Only charges billed by in-network providers will accrue toward the Total Maximum Out-of-Pocket for in-network services. Prescription drug co-payments specified below continue to apply even after the Total Maximum Out-of-Pocket is satisfied in a Benefit Year.		
Annual Maximum Paid per Covered Person per Benefit Year for All Covered Expenses	Unlimited	
Outpatient Physician Services (Includes Office Visits, Immediate Care Center Visits, and Second Surgical Opinions)		
Physician's Fee for an Examination	$20 co-payment per visit, then 100%; deductible waived	60% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; benefit percentage depends upon the type of service rendered	Paid the same as any other illness; benefit percentage depends upon the type of service rendered
Routine Preventive Care Physician's Fee for an Examination Routine X-Rays and Lab Tests Flu Shots and Other Routine Immunizations FDA-Approved Contraceptive Methods and Sterilization Procedures for Women with Reproductive Capacity Mammograms, Colonoscopies, and Other Routine Services	100%; deductible waived	Not covered
Special Notes about Routine Preventive Care: 1. Co-insurance or an office visit co-payment may be imposed on preventive care services if either the visit is billed separately from the preventive care service or the services are provided during an office visit whose primary purpose is not preventive care (and the services are not billed separately). 2. The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.		

Premier Plan

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

Benefit Description		
	In-Network	**Out-Of-Network**
Emergency Room Treatment		
Physician's Fee for an Examination in the Emergency Room	90% after deductible	Paid as in-network
All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment	90% after deductible	Paid as in-network if treated at an in-network facility, or at 60% after deductible if treated at an out-of-network facility
Hospital's Fee for the Use of the Emergency Room	$250 co-payment* per visit, then 100%; deductible waived *may waive if admitted	Paid as in-network
All Other Services Billed by the Hospital or Any Other Provider in Connection with the Emergency Room Visit	90% after deductible	60% after deductible
Ambulance Transportation	90% after deductible	Paid as in-network if delivered to an in-network facility, or at 60% after deductible if delivered to an out-of-network facility
Prescription Drugs		
Retail Prescription Drug Co-payments	$-0-/for prescription of over-the-counter forms of Claritin or Prilosec 25% of the purchase price ($-0- minimum or $60 maximum) for all generic and brand-name prescription drugs	
Mail-Order Prescription Drug Co-payments (90-Day Supply)	$-0-/for prescription of over-the-counter forms of Claritin or Prilosec 25% of the purchase price ($-0- minimum or $120 maximum) for all generic and brand-name prescription drugs	

Special Notes about Prescription Drug Coverage:

1. The pharmacy will dispense generic drugs unless the prescribing physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the covered person refuses an available generic equivalent and the prescribing physician has not requested DAW, the covered person must pay the applicable co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.
2. Over-the-counter forms of Claritin and Prilosec will be covered under the Plan and shall be subject to the co-payments shown above. A physician's prescription for these products is required.
3. A covered person may purchase a 31- to 90-day supply of a drug that is classified by the PBM as a "Maintenance Medication" at a retail pharmacy; however, when such a quantity of a Maintenance Medication is purchased, the maximum co-payment charged at a retail pharmacy shall be increased from $60 to $180.
4. Prescription drugs prescribed for the treatment of infertility are eligible for coverage under the Plan, subject to the co-payments stated above. However, the Plan will only cover one 60-day supply per covered person in a lifetime.
5. All generic contraceptives and all brand contraceptives that do not have a generic equivalent are covered at 100% with no co-payment. All brand contraceptives that do have a generic equivalent are covered at the co-payments stated above.
6. Some smoking cessation intervention products are covered at 100% with no co-payment when prescribed by a physician. To obtain more information about smoking cessation intervention products covered under the Plan at 100% with no co-payment, the covered person can call the Pharmacy Benefit Manager's phone number listed on the front of his or her identification card.

Authorization Requirement $250 Penalty for Non-Compliance	Required for all inpatient hospital confinements and observational stays at the hospital, home and outpatient rehabilitative therapy, rental and purchase of durable medical equipment or purchase of custom-made orthotic or prosthetic appliances, home health care, and oncology treatment.	
Inpatient Hospital Services Room and Board, Surgical Services, and Ancillary Services	90% after deductible	60% after deductible

Premier Plan

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

Benefit Description	In-Network	Out-Of-Network
Other Outpatient Services Surgery and Surgery-Related Services Chemotherapy and Radiation Therapy Hemodialysis Durable Medical Equipment Prosthetics and Orthotics	90% after deductible	60% after deductible
Diagnostic X-Ray and Lab Services (Including Allergy Testing)	100% after deductible	60% after deductible
Pre-Admission Testing	100% after deductible	60% after deductible
Chiropractic Care and Massage Therapy		
Medically Necessary Massage Therapy Services	50% after deductible	50% after deductible
Chiropractic Spinal Manipulations and Therapy Treatments	100%; deductible waived	100%; deductible waived
Chiropractic Diagnostic Spinal X-Rays	100%; deductible waived	100%; deductible waived
Chiropractor's Fee for an Initial or Periodic Evaluation	$20 co-payment per visit, then 100%; deductible waived	$20 co-payment per visit, then 100%; deductible waived
$500 Maximum Paid per Covered Person per Benefit Year for All Chiropractic Care and Massage Therapy Combined (In-Network and Out-of-Network Services Combined)		
Rehabilitative Therapy Physical Therapy, Speech Therapy, and Occupational Therapy	90% after deductible	60% after deductible
Convalescent Care, Home Health Care, and Hospice	90% after deductible	60% after deductible

If a covered person receives eligible treatment at an in-network facility, any anesthesiology, pathology, or radiology charges will be paid at the in-network benefit percentage, even if out-of-network providers performed those services. However, charges in excess of the usual and customary limitation will not be eligible under the Plan. Additionally, this practice of paying in-network-level benefits for services rendered by out-of-network providers may be expanded in certain situations if the proper referral procedures have been followed. Any such referrals must be approved by the Utilization Review Firm. Please see the Utilization of In-Network Providers section of the Plan document for additional information.

If a Participant receives treatment from an out-of-network provider while traveling on Andrews University business, all eligible claims will be paid at the in-network level.

Motor Vehicle Exclusion (Michigan Residents Only)

BENEFITS ARE NOT PAYABLE UNDER THIS PLAN FOR INJURIES RECEIVED IN AN ACCIDENT INVOLVING A MOTOR VEHICLE AS DEFINED IN THE PLAN. It is your responsibility to obtain proper motor vehicle insurance that will give you and your family medical benefits. If you fail to maintain your motor vehicle insurance, you will not have any medical expense coverage for auto-related injuries. This exclusion shall not apply to a covered person who is a Michigan resident involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion shall apply if a covered person is injured while in his or her own uninsured motor vehicle for which a Michigan no-fault policy is legally required and would have provided coverage, had such a policy been in effect.

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents (Non-Michigan Residents Only)

In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary Plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Effective July 1, 2014

This brochure represents only a summary of your group health benefits Plan as it applies to all eligible employees and dependents. This brochure is not the Plan Document or the Summary Plan Description and shall not be relied upon to establish or determine eligibility, benefits, procedures, or the content or validity of any section or provision of the Health Benefits Plan. Please refer to the Health Benefits Plan Document for specific information regarding Plan provisions.

Standard Plan

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

Benefit Description		
	In-Network	**Out-Of-Network**
Benefit Year	July 1 through June 30	
Deductible per Benefit Year	$550 / person $1,100 / family	$3,000 / person $6,000 / family
Special Note About the Benefit Year Deductible: Only charges billed by in-network providers will accrue toward the deductible for in-network services, and only charges billed by out-of-network providers will accrue toward the deductible for out-of-network services.		
General Benefit Percentage	80% after deductible (20% coinsurance)	60% after deductible (40% coinsurance)
Coinsurance Maximum Out-Of-Pocket per Benefit Year	$3,700 / person* $7,400 / family*	$5,000 / person* $10,000 / family*
*Only charges billed by in-network providers will accrue toward the Coinsurance Maximum Out-of-Pocket for in-network services, and only charges billed by out-of-network providers will accrue toward the Coinsurance Maximum Out-of-Pocket for out-of-network services.		
Total Maximum Out-Of-Pocket per Benefit Year (Includes Deductible, Coinsurance, and Medical Co-payments Only)	$6,350 / person** $12,700 / family**	Not applicable
**Does not include prescription drug co-payments or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. Only charges billed by in-network providers will accrue toward the Total Maximum Out-of-Pocket for in-network services. Prescription drug co-payments specified below continue to apply even after the Total Maximum Out-of-Pocket is satisfied in a Benefit Year.		
Annual Maximum Paid per Covered Person per Benefit Year for All Covered Expenses	Unlimited	
Outpatient Physician Services (Includes Office Visits, Immediate Care Center Visits, and Second Surgical Opinions)		
Physician's Fee for an Examination	$30 co-payment per visit, then 100%; deductible waived	60% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; benefit percentage depends upon the type of service rendered	Paid the same as any other illness; benefit percentage depends upon the type of service rendered
Routine Preventive Care Physician's Fee for an Examination Routine X-Rays and Lab Tests Flu Shots and Other Routine Immunizations FDA-Approved Contraceptive Methods and Sterilization Procedures for Women with Reproductive Capacity Mammograms, Colonoscopies, and Other Routine Services	100%; deductible waived	Not covered
Special Notes about Routine Preventive Care: 1. Co-insurance or an office visit co-payment may be imposed on preventive care services if either the visit is billed separately from the preventive care service or the services are provided during an office visit whose primary purpose is not preventive care (and the services are not billed separately). 2. The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.		

Standard Plan

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

Benefit Description		
	In-Network	**Out-Of-Network**
Emergency Room Treatment		
Physician's Fee for an Examination in the Emergency Room	80% after deductible	Paid as in-network
All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment	80% after deductible	Paid as in-network if treated at an in-network facility, or at 60% after deductible if treated at an out-of-network facility
Hospital's Fee for the Use of the Emergency Room	$250 co-payment* per visit, then 100%; deductible waived *may waive if admitted	Paid as in-network
All Other Services Billed by the Hospital or Any Other Provider in Connection with the Emergency Room Visit	80% after deductible	60% after deductible
Ambulance Transportation	80% after deductible	Paid as in-network if delivered to an in-network facility, or at 60% after deductible if delivered to an out-of-network facility
Prescription Drugs		
Retail Prescription Drug Co-payments	$-0-/for prescription of over-the-counter forms of Claritin or Prilosec 35% of the purchase price ($-0- minimum or $60 maximum) for all generic and brand-name prescription drugs	
Mail-Order Prescription Drug Co-payments (90-Day Supply)	$-0-/for prescription of over-the-counter forms of Claritin or Prilosec 35% of the purchase price ($-0- minimum or $120 maximum) for all generic and brand-name prescription drugs	

Special Notes about Prescription Drug Coverage:

1. The pharmacy will dispense generic drugs unless the prescribing physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the covered person refuses an available generic equivalent and the prescribing physician has not requested DAW, the covered person must pay the applicable co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.
2. Over-the-counter forms of Claritin and Prilosec will be covered under the Plan and shall be subject to the co-payments shown above. A physician's prescription for these products is required.
3. A covered person may purchase a 31- to 90-day supply of a drug that is classified by the PBM as a "Maintenance Medication" at a retail pharmacy; however, when such a quantity of a Maintenance Medication is purchased, the maximum co-payment charged at a retail pharmacy shall be increased from $60 to $180.
4. Prescription drugs prescribed for the treatment of infertility are eligible for coverage under the Plan, subject to the co-payments stated above. However, the Plan will only cover one 60-day supply per covered person in a lifetime.
5. All generic contraceptives and all brand contraceptives that do not have a generic equivalent are covered at 100% with no co-payment. All brand contraceptives that do have a generic equivalent are covered at the co-payments stated above.
6. Some smoking cessation intervention products are covered at 100% with no co-payment when prescribed by a physician. To obtain more information about smoking cessation intervention products covered under the Plan at 100% with no co-payment, the covered person can call the Pharmacy Benefit Manager's phone number listed on the front of his or her identification card.

Authorization Requirement $250 Penalty for Non-Compliance	Required for all inpatient hospital confinements and observational stays at the hospital, home and outpatient rehabilitative therapy, rental and purchase of durable medical equipment or purchase of custom-made orthotic or prosthetic appliances, home health care, and oncology treatment.	
Inpatient Hospital Services Room and Board, Surgical Services, and Ancillary Services	80% after deductible	60% after deductible

Benefit Description	In-Network	Out-Of-Network
Other Outpatient Services Surgery and Surgery-Related Services Chemotherapy and Radiation Therapy Hemodialysis Durable Medical Equipment Prosthetics and Orthotics	80% after deductible	60% after deductible
Diagnostic X-Ray and Lab Services (Including Allergy Testing)	100% after deductible	60% after deductible
Pre-Admission Testing	100% after deductible	60% after deductible
Chiropractic Care and Massage Therapy		
Medically Necessary Massage Therapy Services	50% after deductible	50% after deductible
Chiropractic Spinal Manipulations and Therapy Treatments	100%; deductible waived	100%; deductible waived
Chiropractic Diagnostic Spinal X-Rays	100%; deductible waived	100%; deductible waived
Chiropractor's Fee for an Initial or Periodic Evaluation	$30 co-payment per visit, then 100%; deductible waived	$30 co-payment per visit, then 100%; deductible waived
$500 Maximum Paid per Covered Person per Benefit Year for All Chiropractic Care and Massage Therapy Combined (In-Network and Out-of-Network Services Combined)		
Rehabilitative Therapy Physical Therapy, Speech Therapy, and Occupational Therapy	80% after deductible	60% after deductible
Convalescent Care, Home Health Care, and Hospice	80% after deductible	60% after deductible

If a covered person receives eligible treatment at an in-network facility, any anesthesiology, pathology, or radiology charges will be paid at the in-network benefit percentage, even if out-of-network providers performed those services. However, charges in excess of the usual and customary limitation will not be eligible under the Plan. Additionally, this practice of paying in-network-level benefits for services rendered by out-of-network providers may be expanded in certain situations if the proper referral procedures have been followed. Any such referrals must be approved by the Utilization Review Firm. Please see the Utilization of In-Network Providers section of the Plan document for additional information.

If a Participant receives treatment from an out-of-network provider while traveling on Andrews University business, all eligible claims will be paid at the in-network level.

Motor Vehicle Exclusion (Michigan Residents Only)
BENEFITS ARE NOT PAYABLE UNDER THIS PLAN FOR INJURIES RECEIVED IN AN ACCIDENT INVOLVING A MOTOR VEHICLE AS DEFINED IN THE PLAN. It is your responsibility to obtain proper motor vehicle insurance that will give you and your family medical benefits. If you fail to maintain your motor vehicle insurance, you will not have any medical expense coverage for auto-related injuries. This exclusion shall not apply to a covered person who is a Michigan resident involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion shall apply if a covered person is injured while in his or her own uninsured motor vehicle for which a Michigan no-fault policy is legally required and would have provided coverage, had such a policy been in effect.

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents (Non-Michigan Residents Only)
In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary Plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Effective July 1, 2014

This brochure represents only a summary of your group health benefits Plan as it applies to all eligible employees and dependents. This brochure is not the Plan Document or the Summary Plan Description and shall not be relied upon to establish or determine eligibility, benefits, procedures, or the content or validity of any section or provision of the Health Benefits Plan. Please refer to the Health Benefits Plan Document for specific information regarding Plan provisions.

QHDHP Plan

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

Benefit Description		
	In-Network	**Out-Of-Network**
Benefit Year	July 1 through June 30	
Deductible per Benefit Year	$1,350 / single $2,700 / family	$3,000 / single $6,000 / family
Special Note about the Benefit Year Deductible: The family deductible must be met in full, either by one covered family member or by any combination of covered family members, before the Plan will begin paying benefits for any individual. Only charges billed by in-network providers will accrue toward the deductible for in-network services, and only charges billed by out-of-network providers will accrue toward the deductible for out-of-network services.		
General Benefit Percentage	80% after deductible (20% coinsurance)	60% after deductible (40% coinsurance)
Total Maximum Out-Of-Pocket per Benefit Year (Includes Deductible, Coinsurance, and Medical and Prescription Drug Co-payments)	$3,150 / single* $6,300 / family*	$8,000 / single* $16,000 / family*
*Does not include expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. Only charges billed by in-network providers will accrue toward the Total Maximum Out-of-Pocket for in-network services, and only charges billed by out-of-network providers will accrue toward the Total Maximum Out-of-Pocket for out-of-network services. The family Total Maximum Out-of-Pocket must be met in full, either by one covered family member or by any combination of covered family members, before the Plan's benefits will increase to 100%.		
Annual Maximum Paid per Covered Person per Benefit Year for All Covered Expenses	Unlimited	
Outpatient Physician Services (Includes Office Visits, Immediate Care Center Visits, and Second Surgical Opinions)		
Physician's Fee for an Examination	80% after deductible	60% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; benefit percentage depends upon the type of service rendered	Paid the same as any other illness; benefit percentage depends upon the type of service rendered
Routine Preventive Care Physician's Fee for an Examination Routine X-Rays and Lab Tests Flu Shots and Other Routine Immunizations FDA-Approved Contraceptive Methods and Sterilization Procedures for Women with Reproductive Capacity Mammograms, Colonoscopies, and Other Routine Services	100%; deductible waived	Not covered
Special Notes about Routine Preventive Care: 1. Co-insurance or an office visit co-payment may be imposed on preventive care services if either the visit is billed separately from the preventive care service or the services are provided during an office visit whose primary purpose is not preventive care (and the services are not billed separately). 2. The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.		

Benefit Description		
	In-Network	**Out-Of-Network**
Emergency Room Treatment		
Physician's Fee for an Examination in the Emergency Room	80% after deductible	Paid as in-network
All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment	80% after deductible	Paid as in-network if treated at an in-network facility, or at 60% after deductible if treated at an out-of-network facility
Hospital's Fee for the Use of the Emergency Room	80% after deductible	Paid as in-network
All Other Services Billed by the Hospital or Any Other Provider in Connection with the Emergency Room Visit	80% after deductible	60% after deductible
Ambulance Transportation	80% after deductible	Paid as in-network if delivered to an in-network facility, or at 60% after deductible if delivered to an out-of-network facility
Prescription Drugs		
Drugs Purchased Before the In-Network Deductible is Satisfied	The covered person must pay the full cost of the prescription at the time of purchase. The amount paid to purchase an eligible prescription drug will apply toward the deductible. If an eligible prescription drug is purchased at a pharmacy within the appropriate network or through the Mail Service Program, the covered person may receive a discount toward the purchase price of the drug. The availability and amount of the discount will depend on the type of medication and the dosage.	
Drugs Purchased After the In-Network Deductible is Satisfied		
• Retail Prescription Drug Co-payments (90-Day Supply)	20% of the purchase price	
• Mail-Order Prescription Drug Co-payments (90-Day Supply)	20% of the purchase price	
Drugs Purchased After the In-Network Total Maximum Out-of-Pocket is Satisfied	Plan pays 100% of the purchase price; no co-payment applies	

Special Notes about Prescription Drug Coverage:

1. The pharmacy will dispense generic drugs unless the prescribing physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the covered person refuses an available generic equivalent and the prescribing physician has not requested DAW, the covered person must pay the applicable co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.
2. Over-the-counter forms of Claritin and Prilosec will be covered under the Plan and shall be subject to the co-payments shown above after the in-network deductible has been met. After the in-network out-of-pocket maximum is met, no co-payment shall apply for the rest of the Benefit Year. A physician's prescription for these products is required.
3. Prescription drugs prescribed for the treatment of infertility are eligible for coverage under the Plan and shall be subject to the co-payments stated above after the in-network deductible has been met. However, the Plan will only cover one 60-day supply per covered person in a lifetime.
4. All generic contraceptives and all brand contraceptives that do not have a generic equivalent are covered at 100% with the deductible waived and no co-payment. All brand contraceptives that do have a generic equivalent are covered subject to the deductible and the co-payments stated above.
5. Some smoking cessation intervention products are covered at 100% with the deductible waived and no co-payment when prescribed by a physician. To obtain more information about smoking cessation intervention products covered under the Plan at 100% with the deductible waived and no co-payment, the covered person can call the Pharmacy Benefit Manager's phone number listed on the front of his or her identification card.

Authorization Requirement $250 Penalty for Non-Compliance	Required for all inpatient hospital confinements and observational stays at the hospital, home and outpatient rehabilitative therapy, rental and purchase of durable medical equipment or purchase of custom-made orthotic or prosthetic appliances, home health care, and oncology treatment.	
Inpatient Hospital Services Room and Board, Surgical Services, Pre-Admission Testing, and Ancillary Services	80% after deductible	60% after deductible

QHDHP Plan

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

Benefit Description	In-Network	Out-Of-Network
Other Outpatient Services Surgery and Surgery-Related Services Chemotherapy and Radiation Therapy Hemodialysis Durable Medical Equipment Prosthetics and Orthotics	80% after deductible	60% after deductible
Diagnostic X-Ray and Lab Services (Including Allergy Testing)	80% after deductible	60% after deductible
Chiropractic Care and Massage Therapy		
Medically Necessary Massage Therapy Services	50% after deductible	50% after deductible
Chiropractic Spinal Manipulations and Therapy Treatments	80% after deductible	Paid as in-network
Chiropractic Diagnostic Spinal X-Rays	80% after deductible	Paid as in-network
Chiropractor's Fee for an Initial or Periodic Evaluation	80% after deductible	Paid as in-network
$500 Maximum Paid per Covered Person per Benefit Year for All Chiropractic Care and Massage Therapy Combined (In-Network and Out-of-Network Services Combined)		
Rehabilitative Therapy Physical Therapy, Speech Therapy, and Occupational Therapy	80% after deductible	60% after deductible
Convalescent Care, Home Health Care, and Hospice	80% after deductible	60% after deductible

If a covered person receives eligible treatment at an in-network facility, any anesthesiology, pathology, or radiology charges will be paid at the in-network benefit percentage, even if out-of-network providers performed those services. However, charges in excess of the usual and customary limitation will not be eligible under the Plan. Additionally, this practice of paying in-network-level benefits for services rendered by out-of-network providers may be expanded in certain situations if the proper referral procedures have been followed. Any such referrals must be approved by the Utilization Review Firm. Please see the Utilization of In-Network Providers section of the Plan document for additional information.

If a Participant receives treatment from an out-of-network provider while traveling on Andrews University business, all eligible claims will be paid at the in-network level.

Motor Vehicle Exclusion (Michigan Residents Only)

BENEFITS ARE NOT PAYABLE UNDER THIS PLAN FOR INJURIES RECEIVED IN AN ACCIDENT INVOLVING A MOTOR VEHICLE AS DEFINED IN THE PLAN. It is your responsibility to obtain proper motor vehicle insurance that will give you and your family medical benefits. If you fail to maintain your motor vehicle insurance, you will not have any medical expense coverage for auto-related injuries. This exclusion shall not apply to a covered person who is a Michigan resident involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion shall apply if a covered person is injured while in his or her own uninsured motor vehicle for which a Michigan no-fault policy is legally required and would have provided coverage, had such a policy been in effect.

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents (Non-Michigan Residents Only)

In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary Plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Effective July 1, 2014

This brochure represents only a summary of your group health benefits Plan as it applies to all eligible employees and dependents. This brochure is not the Plan Document or the Summary Plan Description and shall not be relied upon to establish or determine eligibility, benefits, procedures, or the content or validity of any section or provision of the Health Benefits Plan. Please refer to the Health Benefits Plan Document for specific information regarding Plan provisions.

Dental and Vision Plan

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

Benefit Description	Dental Plan
	Limits
Benefit Year	July 1 through June 30
Benefit Percentage	
Type I - Preventive Dental Services	100%
Type II - Minor Restorative Dental Services	75%
Type III - Major Restorative Dental Services	75%
Type IV - Orthodontic Services (for Dependent children under age 24 only)	50%
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II & III Dental Services Claims for Type I Preventive Dental Services incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	$1,000
Lifetime Maximum Benefit Paid per Dependent Child for Type IV Orthodontic Services	$1,760

Benefit Description	Vision Plan
	Limits
Benefit Year	July 1 through June 30
Vision Examinations	$15 co-payment per exam*, then 100% *Eligible charges for routine vision exams for covered persons under age 18 will be paid at 100% and no co-payment shall apply.
Other Vision Services	
Eyeglass Frames	100%
Eyeglass Lenses, Including Eyeglass Lens Add-Ons Such As Tinting, Ultraviolet Coatings, Scratch-Resistant Coatings, and Anti-Reflective Coatings	100%
Contact Lenses	100%
Maximum Benefit Paid per Covered Person per Benefit Year for All Eligible Other Vision Services	$250

Special Provision for Injuries Arising Out of Automobile Accidents

Motor Vehicle Exclusion (Michigan Residents Only)
BENEFITS ARE NOT PAYABLE UNDER THIS PLAN FOR INJURIES RECEIVED IN AN ACCIDENT INVOLVING A MOTOR VEHICLE AS DEFINED IN THE PLAN. It is your responsibility to obtain proper motor vehicle insurance that will give you and your family benefits. If you fail to maintain your motor vehicle insurance, you will not have any coverage for auto-related injuries. This exclusion shall not apply to a covered person who is a Michigan resident involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion shall apply if a covered person is injured while in his or her own uninsured motor vehicle for which a Michigan no-fault policy is legally required and would have provided coverage, had such a policy been in effect.

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents (Non-Michigan Residents Only)
In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Effective July 1, 2014

This brochure represents only a summary of your group health benefits Plan as it applies to all eligible employees and dependents. This brochure is not the Plan Document or the Summary Plan Description and shall not be relied upon to establish or determine eligibility, benefits, procedures, or the content or validity of any section or provision of the Health Benefits Plan. Please refer to the Health Benefits Plan Document for specific information regarding Plan provisions.

FSA / Limited Purpose FSA

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

FLEXIBLE SPENDING ACCOUNTS

Your employer is giving you the opportunity to enroll in an employee benefit plan called a flexible spending account (FSA) through Section 125 of the Internal Revenue Code. FSAs are employer-established benefit plans that are generally funded with pretax contributions by employees. Employers may also contribute to an FSA, and these contributions can be excluded from your gross income for tax purposes.

The Internal Revenue Service (IRS) has set limits on the amount of money that you can contribute to an FSA, and employers generally set a minimum contribution. You can withdraw funds from the account to pay for qualified medical expenses even if you have not yet placed the funds in the account.

The main disadvantage of an FSA is the use-or-lose rule, which states that any unspent funds remaining at the plan year's end will revert back to the plan, not to you. You may minimize this potential risk by allocating only enough pretax dollars to cover expenses that you expect to incur in the coming plan year.

MEDICAL FSA – Maximum Contribution $2,500

A medical FSA covers eligible health-care expenses not reimbursed by any medical, dental, or vision care plan you or your dependents may have (but not health insurance premiums). You may submit claims for yourself and your eligible dependents, including your spouse, children, and any other person who is a qualified IRS dependent.

If you participate in a health savings account (HSA), you may be reimbursed under the medical FSA only for uninsured dental and vision care expenses, preventive care (such as annual physicals; routine tests, immunizations, and well-child care; tobacco cessation; and obesity weight-loss programs), and other expenses incurred after the minimum annual deductible under your high-deductible health plan is satisfied. Further, you cannot submit claims to both your medical FSA and your HSA for the same expense.

If you are terminated, and the contributions made to your medical FSA as of the date of termination exceed the claims submitted, you may continue participation through COBRA.

Eligible Expenses

Acupuncture
Alcoholism or drug treatment
Ambulances
Birth control
Body scans
Car controls (handicapped equipment)
Chiropractors
Contact lenses
Cosmetic surgery (medically necessary)
Crutches
Deductibles and co-payments
Dental and vision expenses
Diagnostic tests (pregnancy tests, ovulation monitors, cholesterol and blood pressure tests)
Doctor's fees
Eyeglasses
Guide dogs
Health care equipment
Hearing aids
Hypnosis (for treatment of disease)
Immunizations
Lab fees
Lasik (Laser) eye surgery
Learning disabilities (instructional fees)
Lifetime care
Massage therapy (prescribed by a physician to treat a specific medical condition)
Nursing services (medically necessary)
Optometrist's fees
Over-the-counter drugs (if prescribed to alleviate or treat illness or injury)
Physical therapy
Prescription drugs
Smoking cessation aids/programs
Sterilization
Surgery (general)
Syringes
Teeth whitening (to correct discoloration caused by disease, birth defect, or injury)
Television (closed captioned)
Vitamins and minerals (prescription only)
Weight loss programs (only as treatment for obesity, heart disease, or diabetes; includes fees and expenses)
Well-baby care
Wheelchairs
X-rays

Ineligible Expenses

Bottled water
Cosmetics, toiletries, toothpaste, etc.
Custodial care in an institution
Electrolysis
Food for weight-loss programs
Funeral and burial expenses
Health club dues
Household and domestic help
Insurance premiums
Long-term care
Marriage or family counseling
Maternity clothes, diaper services, etc.
Meals and general budgeting
Uniforms
Vitamins taken for general health purposes

ASR health benefits

The medical FSA operates much like a bank account. Deposits are made into the account in the form of pretax payroll deductions. Withdrawals from the account are made using a flex reimbursement form. You should submit the reimbursement form and a copy of your receipt or bill to ASR Health Benefits, who will then issue you a check. However, other more convenient methods of reimbursement do exist, such as a Benefits (debit) Card and direct deposit.

You must decide if the medical FSA is right for you based upon your past medical expenses and future needs. Review your past medical expenses very closely and plan carefully. Also, note the deductible, coinsurance, and co-payment amounts required in the health plan option that you have selected. These amounts can be reimbursed to you through your medical FSA.

You will receive a statement from ASR Health Benefits before the end of the plan year to help you manage this account. For a complete list of eligible and ineligible medical expenses, refer to Internal Revenue Publication 502 at www.irs.gov.

DEPENDENT CARE FSA

With the dependent care FSA, you can reduce your tax burden by using pretax dollars to pay expenses for eligible child care or adult care for senior citizen dependents that live with you. Federal law also allows you to claim a direct credit against federal income taxes for eligible child or dependent care expenses. However, any amount you claim under the dependent care tax credit will be reduced by the amount you are reimbursed under the dependent care FSA. The amount reimbursed under the dependent care FSA reduces, dollar-for-dollar, the amount of dependent care expenses that are eligible for the dependent care tax credit; therefore, you should either participate in the dependent care FSA to the fullest extent possible or claim the tax credit.

The dependent care FSA operates much like a bank account. Deposits are made into the account in the form of pretax payroll deductions. Withdrawals from the account are made using a flex reimbursement form. You should submit the reimbursement form and a copy of your receipt or bill to ASR Health Benefits, who will then issue you a check. However, other more convenient methods of reimbursement do exist, such as a Benefits (debit) Card and direct deposit.

Dependent care expenses are expenses incurred by you to enable you to work. If you are married, the expenses must be incurred to enable you and your spouse to work, or to enable your spouse to attend school on a full-time basis. The expenses must be for the care of your dependent who is under age 13 and for whom a personal-exemption deduction is allowed for federal income tax purposes, for the care of your dependent or spouse who is physically or mentally incapable of self-care, or for household services in connection with the care of a qualifying dependent.

The maximum amount that can be reimbursed (i.e., deposited) is the lowest of your earned income, your spouse's earned income, or $5,000.00 ($2,500.00 if you are married and you file a separate tax return). If your spouse is a full-time student or is incapable of self-care, your spouse's earned income is assumed to be not less than $250.00 if you provide care for one dependent, or $500.00 for two or more dependents, for each month that your spouse is a student or incapable of self-care.

You will receive a statement from ASR Health Benefits before the end of the plan year to help you manage this account. Please refer to Internal Revenue Publication 503 for more information on eligible and ineligible expenses at www.irs.gov.

If you terminate participation before the end of the plan year with a balance in your dependent care FSA, employers have the option to allow you to spend the balance on eligible dependent care expenses incurred during the balance of the plan year. However, you will not be eligible to have additional amounts allocated to your dependent care FSA.

FSA / Limited Purpose FSA

ASR Health Benefits – 30 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

ASR health benefits

DEBIT CARD

You may use the ASR Health Benefits Card to pay for eligible expenses with funds from your own medical or dependent care flexible spending account (FSA) at the time and place the expense is incurred. The Benefits Card operates within the MasterCard® credit card network.

Your card will be accepted at most service providers and merchants where FSA-eligible expenses can be purchased, including hospitals, doctor's offices, dental offices, optical stores, pharmacies, and even some day-care centers. The Benefits Card works like a credit card, and no PIN or procedure for activating the card is required.

When you use your Benefits Card, you will not have to pay for the expense, file substantiating documentation with a request for reimbursement, and then wait for the refund check to come. Most merchants now have what is called an inventory information approval system (IIAS) in place to ensure FSA debit cards are used only for medical expenses that are FSA eligible. Examples of these merchants are drug stores, pharmacies, and grocery stores. Because more items in these stores will be identified as FSA eligible through IIAS, you will not have to substantiate, or prove, as many of the FSA-eligible items that you purchase with your Benefits Card.

Make sure that you use your Benefits Card only for FSA-eligible expenses! If you purchase an ineligible item using your Benefits Card, you will have to write a personal check to reimburse your FSA account or the amount will be deducted from a future claim request.

In order to purchase over-the-counter (OTC) medications with debit cards, you must present a prescription for an OTC medication to your pharmacy or your mail-order or Web-based vendor that dispenses the medication and retain proper records of the transaction. However, you may purchase non-medicine OTC items, such as bandages, blood sugar test kits, and test strips, with the Benefits Card at merchants that have an IIAS in place or you may purchase them manually, without a prescription.

If you have any questions about the Benefits Card, call ASR Health Benefits at (800) 968-2449.

GRACE PERIOD

Your flexible spending account (FSA) has a two and one-half month grace period at the end of the plan year. This grace period is a period of time when you may incur qualified medical expenses and pay them from any amounts left in your FSA at the end of the previous year. The grace period ends on the 15th day of the third month of the next plan year, but you will usually have a time period after that in which to submit (but not incur) the claims.

Here is an example of how the grace period works:

> Your plan year runs from July 1 through June 30 and has a two and one-half month grace period. You have three months after the grace period to submit claims incurred during the plan year and the grace period. At the end of June 2014, you have $250 left in your medical FSA. You incur $250 of qualified medical expenses during July 1 through September 15 of 2014, the grace period for the 2013-14 plan year. These expenses are eligible to be submitted for the 2013-14 plan year. You may submit these expenses before December 15, 2014 in order to receive reimbursement.

You must forfeit any funds remaining in your FSA at the end of the grace period. The grace period may be added to a medical FSA or a dependent care FSA. Ask your employer for details.

If you have any questions about the grace period, call ASR Health Benefits at (800) 968-2449.

Andrews University

AHealthyU Wellness Program
Action Year 2014 for Benefit Year 2014-2015

Who is eligible to participate in the program?

All employees and spouses covered under the Andrews University medical benefit plan[1]

What are the program requirements?

1. **Meet the 2014-2015 biometric[2] targets** with **current biometrics***
   On-site biometric health screens will be held at Andrews University on March 26 & 27 at 6:30 to 11:00 AM. Alternatively, a Primary Care Provider wellness verification form may be submitted to Lakeland. Lakeland Care Health Management Advisors will be on-site to review biometric results from the March health screens on April 9 & 10 from 8:00 to 5:00 PM.

2. **Meet with a Benefit Enrollment Counselor**

2014-2015 Health Target Table

Health Screen	Health Target	Health Risk	Actionable Value	Critical Value
Blood Pressure	< 140/90	≥ 140/90	≥ 160/100	≥ 180/110
HA1C	< 6.0%	≥ 6.0 – 7.5%	≥ 7.5 – 8.9%	≥ 9.0%
Triglyceride	< 150 mg/dl	≥ 150	≥ 300	≥ 500
LDL	< 130 mg/dl	≥ 130	≥ 160	≥ 190
BMI	18.5 – 30.0	< 18.5 – 30.0	≥ 35.0	≥ 40.0

***Are my biometrics current?** Lakeland Care will send an e-mail to your Andrews University e-mail address to let you know if you need to participate in the biometric screen:

YES – You participated in 2013 and your biometrics were performed in 2013 AND you had 2 or less health risks. No new biometrics are required.

NO – You did NOT participate in 2013 – You need new biometrics performed in 2014.

NO – You participated in 2013 and your biometrics were performed in 2013 AND you had a critical or actionable value or 3 or more health risks. You need new biometrics performed in 2014.

NO – You participated in 2013 but your biometrics were performed prior to 2013. You need new biometrics performed in 2014.

Alternate Satisfaction of Health Targets
Andrews University is committed to helping you achieve your best health. The reward for participating in the AHealthyU wellness program is available to all employees covered under the Andrews University medical plan. If you are unable to meet the health standards for the reward under this wellness program, you may qualify for an opportunity to earn the same reward by completing an Alternate Satisfaction Activity (see below). Contact Lakeland Care, 269-927-5154 and they will work with you to find a wellness activity with the same reward that is right for you in light of your health status. All Alternate Satisfaction Activities must be completed by May 1, 2014.

Alternate Satisfaction for Biometrics

Health Standard Not Met	Alternate Satisfaction Activities
3 - 5 health standards not met **- or -** You have 1 or more actionable or critical values	Meet with Health Management Advisor and follow plan of care which may include a follow-up visit with physician to develop and/or review plan of care

[1] Both employee and spouse covered under the medical benefit must complete the program requirements to earn the reward.
[2] If you have questions, please e-mail aHealthyU@lakelandregional.org or call Lakeland Care at 269-927-5154.

Basic Life

The Hartford – 35 Hours – AF/SA/SF/FA/FF/FT

What is Basic Life Insurance?

Your Employer provides, at no cost to you, Basic Life Insurance in options in the amount of $50,000 or $100,000. Life Insurance pays your *beneficiary* (please see below) a benefit if you die while you are covered. This highlight sheet is an overview of your Basic Life Insurance. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

Why do I need Basic Life Insurance?

Basic Life Insurance provides affordable financial security for your loved ones, although when it comes down to it, contemplating some pretty unpleasant things is hard to do. But when you consider the fact that between 1995 and 1997, almost 40% of all deaths that occurred were people between the ages of 25 and 64[1], it's harder to ignore. Especially when your family depends on your income.

[1]Death Rates by Age, Sex and Race: 1970 to 1997, U.S. Census Bureau, Statistical Abstract of the United States, 1999, page 95.

Am I eligible?

You are eligible if you are an active full time employee who works at least 35 hours per week on a regularly scheduled basis.

When can I enroll?

As an eligible Employee, you are automatically covered by Basic Life Insurance; you do not have to enroll. If you have not already done so, you must designate a beneficiary as described below.

When is it effective?

Coverage goes into effect subject to the terms and conditions of the policy. In no case will benefits become effective sooner than 7/1/2014 or First of the month following date of hire. You must be Actively at Work with your employer on the day your coverage takes effect.

Benefit Reductions

None. All coverage cancels at retirement.

What is a beneficiary?

Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.

Spouse Basic Life Insurance

Your employer provides, at little or no cost to you, Spouse Basic Life Insurance, in options in the amount equal to $2,000 or $50,000.

The amount of Spouse Basic coverage may never exceed 100% of the Basic Amount of Life Insurance in force for the Employee.

Child Basic Life Insurance

Your employer provides, at no cost to you, Child Basic Life Insurance in options in the amount equal to $2,000, $5,000, or $10,000 for each Child— *no medical information is required*. Child(ren) must be unmarried and are covered from Live Birth to 19 years old or 24 years if they are a full-time student or meet certain other conditions. Stillborn covered at $750.

- Unmarried Child(ren) over age 19 may be covered if they are disabled and primarily dependent upon the Employee for financial support.

Can I keep my Life Coverage if I leave my employer?

Yes, subject to the contract, you have the option of:

- Converting your group Life coverage to your own individual policy (policies).

What is the Living Benefits Option?

If you are diagnosed as terminally ill with a 12 month life expectancy, you may be eligible to receive payment of a portion of your Life Insurance. The remaining amount of your Life Insurance would be paid to your beneficiary when you die.

Important Details

As is standard with most term life Insurance, this Insurance coverage includes certain limitations and exclusions:

- The amount of your coverage may be reduced when you reach certain ages.

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

This Benefit Highlights Sheet is an overview of the Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the Insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your Insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the Insurance policy, the terms of the Insurance policy apply.

Long Term Disability

The Hartford – 35 Hours – AF/SA/SF/FA/FF/FT

What is Employer Paid Long Term Disability Insurance?

Employer Paid Long Term Disability Insurance pays you a portion of your Earnings if you cannot work because of a disabling illness or injury.

This highlight sheet is an overview of your Employer Paid Long Term Disability Insurance. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

What is disability?

Disability is defined in The Hartford's contract with your employer. Disability or Disabled means You are prevented from performing one or more of the Essential Duties of: 1) Your Occupation during the Elimination Period; 2) Your Occupation, for the 24 month(s) following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings; and 3) after that, Any Occupation. If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first.

Am I eligible?

You are eligible if you are an active full time employee who works at least 35 hours per week on a regularly scheduled basis.

How much coverage would I have?

Your Employer Provides coverage that pays you a benefit of 66.67% of your Earnings to a maximum monthly benefit of $6,000 per month. This plan includes a minimum benefit of the greater of: 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits or $100 per month.

Earnings are defined as in The Hartford's contract with your employer.

When can I enroll?

As an eligible Employee, you are automatically covered by Employer Paid Long Term Disability Insurance; you do not have to enroll.

When is it effective?

Coverage goes into effect subject to the terms and conditions of the policy. In no case will newly elected benefits become effective sooner than 7/1/2014 or First of the month following date of hire. You must be Actively at Work with your employer on the day your coverage takes effect.

How long do I have to wait before I can receive my benefit?

You must be disabled for at least 90 days before you can receive an Employer Paid Long Term Disability Insurance benefit payment.

Can the duration or amount of my benefit be reduced?

Yes. Your benefit duration may be reduced once you reach certain ages as specified in The Hartford's contract with your employer. In addition, as described below within the Important Details, your monthly Long-Term benefit may be reduced by other income you receive.

How long will my disability payments continue?

For as long as you remain disabled, or until you reach your Social Security Normal Retirement Age (as stated in the 1983 revision of the United States Social Security Act), whichever is sooner. If your disability occurs at age 65 or above, your payments may be reduced.

Long Term Disability

The Hartford – 35 Hours – AF/SA/SF/FA/FF/FT

Important Details

The following is an overview of your Employer Paid Long Term Disability Insurance. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

Exclusions:

You cannot receive Employer Paid Long Term Disability Insurance benefit payments for disabilities that are caused or contributed to by:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability

You must be under the regular care of a physician to receive benefits.

Mental Illness, Alcoholism and Substance Abuse:

- You can receive benefit payments for Long-Term Disabilities resulting from mental illness, alcoholism and substance abuse for a total of 24 months for all disability periods during your lifetime.
- Any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 24 months lifetime limit.

Pre-existing Conditions:

Your Insurance limits the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your policy, you will be covered for a disability due to that condition only if:

- You have not received treatment for your condition for the length of time specified in the contract before the effective date of your Insurance, or
- You have been insured under this coverage for length of time specified in the contract prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
- You have already satisfied the pre-existing condition requirement of your previous insurer.

Your benefit payments **will be reduced** by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance (please see next section for exceptions)
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)

Your benefit payments **will not be reduced** by certain kinds of other income, such as:

- Retirement benefits if you were already receiving them before you became disabled
- Retirement benefits that are funded by your after-tax contributions
- Your personal savings, investments, IRAs or Keoghs
- Profit-sharing
- Most personal disability policies
- Social Security increases

Travel Assistance & Identity Theft

The Hartford – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

Even the best planned trips can be full of surprises.

The best laid travel plans can go awry, leaving you vulnerable and, possibly, unable to communicate your needs. When the unexpected happens far from home, it's important to know whom to call for assistance.

If you are covered under a Hartford Group Policy, you and your family have access to Travel Assistance Services provided by Europ Assistance USA.

With a local presence in 200 countries and territories around the world, and numerous 24/7 assistance centers, they are available to help you anytime, anywhere.

Good to go: Multilingual assistance 24/7.

Whether you're traveling for business or pleasure, Travel Assistance services are available when you're more than 100 miles from home for 90 days or less.

As long as you contact Europ Assistance USA at the time of need, you could be approved for up to $1 million in covered services.

Services from here to there.

Travel Assistance begins even before you embark, with pre-trip information, and continues throughout your trip. See the list of services in the chart below.

Identity theft assistance, too.

Identity theft, America's fast growing crime, victimizes almost 10 million American consumers each year. Europ Assistance USA helps protect you and your family from its consequences 24/7, at home and when you travel.

In addition to prevention education, this service provides advice and help with administrative tasks resulting from identity theft.

Case illustration: Help a world away.

As a Human Resource Professional, Tammy had always been on the coordinating end of travel services helping her company's employees; but when her daughter was hurt while traveling with her school group in Italy, she suddenly found herself in a different position.

Using the travel assistance medical referral, medical monitoring, and repatriation services from Europ Assistance USA, Tammy's daughter was able to receive immediate medical treatment and was evacuated within 48 hours. The Europ Assistance USA Case Manager helped Tammy through some of the most stressful days she's experienced as a mother and provided care for her daughter when she couldn't.

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES

Emergency Medical Assistance	Pre-trip Information	Emergency Personal Services	Identity Theft Assistance
Medical referrals Medical monitoring Medical evacuation Repatriation Traveling companion assistance Dependent children assistance Visit by a family member or friend Emergency medical payments Return of mortal remains	Visa and passport requirements Inoculation and immunization requirements Foreign exchange rates Embassy and consular referrals	Medication and eyeglass prescription assistance Emergency travel arrangements Emergency cash Locating lost items Bail advancement	Prevention Services - Education - Identity Theft Resolution Kit Detection Services - Fraud alert to three credit bureaus Resolution Guidance and Assistance - Credit information review - ID Theft Affidavit Assistance - Card replacement Personal Services - Translation - Emergency cash advance*

* Cash advance (up to $500) available when theft occurs 100 miles or more from your primary residence. Must be secured by a valid credit card.

DISCLAIMER: Service Exclusions and Limitations: Europ Assistance USA (EA) services are eligible for payment or reimbursement by EA only if EA was contacted at the time of the services and arranged and/or preapproved the services. Certain terms, conditions and exclusions apply; for further information refer to the Web site listed or call EA at the number provided.

Estate Guidance

The Hartford – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

Create a simple will from the convenience of your desktop.

Whether your assets are few or many, it's important to have a will. It's the only way to ensure that your intentions will be honored in the event of your death. A will states your wishes about who will inherit your property, who will be the guardian of your children, and who will manage your estate. Without a will, those decisions may be left to others.

An easy and empowering solution.

As a covered employee under a Hartford Group Life insurance policy, you have access to EstateGuidance® Will Services provided by ComPsych®. It helps you create a simple, legally binding will quickly and conveniently online, saving you the time and expense of a private legal consultation. Other advantages include:

- Online assistance from licensed attorneys should you have questions.
- The ability to save drafts for up to six months. During this period, you can revise your will at no cost, as long as you haven't already printed or downloaded it.
- Additional estate planning services are also available for purchase, including the creation of living wills and trusts, guidance about divorce proceedings, and durable power of attorney.

Case illustration: The final word.

Laura was the single parent of a six-year-old daughter, Amy. She worried that if she were to die, her modest but hard-earned assets would not be available to her daughter.

The cost of a legal will seemed beyond her means until she discovered EstateGuidance® through her group life insurance provider. With it, she was able to appoint her older sister as executor of her will and name her brother and sister-in-law as Amy's legal guardians. She felt better knowing that she would have the final word in protecting her daughter's best interests.

Quick answers to key questions.

Where there's a will, there are bound to be questions. Here are answers to four common ones.

"Isn't will preparation complicated?" Not with EstateGuidance®. You'll be asked a series of questions online that are used to compose your will. In many states, you need only add your signature to make the will valid.

"What if I have questions as I'm creating my will?" The online education center provides answers regarding family law. You can also access fully licensed attorneys who'll respond to you online.

"What about my privacy?" All information is kept secure and confidential with the latest encryption technology.

"So, what happens if I don't create a will?" The state, not you, would decide how your property is distributed. In most states, all of your community and joint property would pass to your spouse if you have one. Separate property is passed according to a complex order of distribution, regardless of your loved ones' wishes. By drafting a will, you can spare them a potentially awkward and contentious situation.

Good intentions aren't enough.

You might have the best of intentions, but without a will, they aren't legally binding. Take this opportunity to put your intentions into action.

Visit www.estateguidance.com/wills today. Use this code: WILLHLF. Then follow the easy steps below:

1. Access The Hartford's EstateGuidance® Will Services online.
2. Sign in to the secure site by entering the access code.
3. Follow the instructions and create your will.
4. Download the final will to your computer and print.
5. Obtain signatures and determine if your will should be notarized.

Need more facts?

Just visit our Web site at thehartford.com/employeebenefits.

Voluntary Supplemental Life

The Hartford – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

What is Supplemental Life Insurance?

Supplemental Life Insurance is coverage that you pay for.

Supplemental Life Insurance pays your *beneficiary* (please see below) a benefit if you die while you are covered.

This highlight sheet is an overview of your Supplemental Life Insurance. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

Why do I need Supplemental Life Insurance?

Supplemental Life Insurance provides affordable financial security for your loved ones, although when it comes down to it, contemplating some pretty unpleasant things is hard to do. But when you consider the fact that between 1995 and 1997, almost 40% of all deaths that occurred were people between the ages of 25 and 64[1], it's harder to ignore. Especially when your family depends on your income.

[1]Death Rates by Age, Sex and Race: 1970 to 1997, U.S. Census Bureau, Statistical Abstract of the United States, 1999, page 95.

Am I eligible?

You are eligible if you are an active full time employee who works at least 35 hours per week and part time who works at least 20 hours per week on a regularly scheduled basis.

When can I enroll?

At annual open enrollment.

When is it effective?

Coverage goes into effect subject to the terms and conditions of the policy. In no case will newly elected benefits become effective sooner than 7/1/2014 or First of the month following date of hire. You must be Actively at Work with your employer on the day your coverage takes effect.

How much Supplemental Life Insurance can I purchase?

You can purchase Supplemental Life Insurance in increments of $10,000.

The maximum amount you can purchase cannot be more than the lesser of 7 times your annual Earnings or $750,000, subject to a minimum of $10,000. Annual Earnings are as defined in The Hartford's contract with your employer.

I already have Supplemental Life Insurance coverage; do I have to do anything?

If you take no action, your coverage and coverage for your eligible dependents will automatically continue with The Hartford subject to the terms of the contract.

Am I guaranteed coverage?

Any employee currently enrolled in the voluntary life will be able to elect up to $150,000 each year with no medical questions. If you are not currently enrolled, medical underwriting is required for any election. Note the guaranteed issue of $250,000 (not to exceed 3x earnings) for new hires will still be applicable.

What is a beneficiary?

Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.

Are there other limitations to enrollment?

If you do not enroll within 31 days of your first day of eligibility, you will be considered a "late entrant." Typically, late entrants must show evidence of insurability and may be responsible for the cost of physical exams or other associated costs if they are required.

Voluntary Supplemental Life

The Hartford – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

Spouse Supplemental Life Insurance

If you elect Supplemental Life Insurance for yourself, you may choose to purchase Spouse Supplemental Life Insurance in increments of $5,000, to a maximum of $250,000.

Coverage cannot exceed 100% of the amount of your Employee Voluntary/Supplemental Life Insurance coverage. You may not elect coverage for your Spouse if they are an active member of the armed forces of any country or international authority, or is already covered as an Employee under this policy.

If your Spouse is confined in a hospital or elsewhere because of disability on the date his or her Insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days.

If you are electing coverage for the first time, or electing to increase your current coverage, your Spouse will be required to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

Child(ren) Supplemental Life Insurance

If you elect Supplemental Life Insurance for yourself, you may choose to purchase Child(ren) Supplemental Life Insurance coverage in increments of $5,000, subject to a minimum of $5,000 and a maximum of $25,000 for each Child— *no medical information is required*. You may not elect coverage for your Child if your Child is an active member of the armed forces of any country or international authority. Stillborn covered at $750.

- If your dependent Child is confined in a hospital or elsewhere because of disability on the date his or her Insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days.

Does my coverage reduce as I get older?

None. All coverage cancels at retirement.

Can I keep my Life coverage if I leave my employer?

Yes, subject to the contract, you have the option of:

- Converting your group Life coverage to your own individual policy (policies).
- If you leave your employer, Portability is an option that allows you to continue your Life Insurance coverage. To be eligible, you must terminate your employment prior to Social Security Normal Retirement Age. This option allows you to continue all or a portion of your Life Insurance coverage under a separate Portability term policy. Portability is subject to a minimum of $5,000 and a maximum of $250,000 and does include coverage for your Spouse and Child(ren) . To elect Portability, you must apply and pay the premium within 31 days of the termination of your Life Insurance. Evidence of Insurability will not be required.

Dependent Spouse Portability is subject to a maximum of $50,000.

Dependent Child Portability is subject to a maximum of $10,000.

Do I still pay my Life Insurance premiums if I become disabled?

If you become totally disabled before age 60 and your disability lasts for at least 9 months, your Life Insurance premium may be waived. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium. Coverage for your dependents will end if the policy terminates.

Important Details

As is standard with most term life Insurance, this Insurance coverage includes limitations and exclusions:

- The amount of your coverage may be reduced when you reach certain ages.
- Death by suicide (two years).

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

This Benefit Highlights Sheet is an overview of the Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the Insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your Insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the Insurance policy, the terms of the Insurance policy apply.

Voluntary Accidental Death

The Hartford – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

What is Voluntary Accidental Death and Dismemberment Insurance?

Voluntary Accidental Death and Dismemberment Insurance pays your *beneficiary* (please see next page) a death benefit if you die due to a covered accident while you are insured. It also pays you a benefit for certain accidental losses. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

- Death benefits are paid in addition to any life Insurance benefits.
- Voluntary Accidental Death and Dismemberment Insurance pays benefits for accidental loss of limbs, thumb and index finger, speech, hearing, and sight.
- Voluntary Accidental Death and Dismemberment Insurance covers losses that occur away from work or at work. Benefits are paid regardless of any Worker's Compensation benefits you collect.

This highlight sheet is an overview of your Voluntary Accidental Death and Dismemberment Insurance.

Why do I need Voluntary Accidental Death and Dismemberment Insurance?

The need to protect yourself and your family from the financial consequences of a severe injury, paralysis or death resulting from an accident at or outside of work is real. According to the National Safety Council, about one in eight Americans is seriously injured in an accident each year[1]. Accident Insurance from The Hartford shields you and your family from income loss whether at home or away from home.

[1] National Safety Council: Report on Injuries in America, 2005.

Am I eligible?

You are eligible if you are an active full time employee who works at least 30 hours per week and part time employee who works at least 20 hours.

When can I enroll?

At annual open enrollment.

What does Voluntary Accidental Death and Dismemberment Insurance cover?

You may receive benefits due to certain losses or death from an accident. The covered losses or death can occur up to 365 days after that accident. The policy pays for:

- 100% of the amount of coverage you purchase in the event of accidental loss of life, or speech and hearing in both ears.
- One-half (50%) for accidental loss of one hand or foot, sight of one eye, or speech or hearing in both ears.
- One-quarter (25%) for accidental loss of thumb and index finger of the same hand.

Additionally, your Employer may have elected optional/supplemental benefits as part of your AD&D coverage. Refer to the certificate of Insurance for further information.

Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage you purchase.

What optional benefits has my Employer selected as part of my Voluntary Accidental Death and Dismemberment Insurance?

- Accident Hospital Income
- Child Education Benefit
- Common Disaster Benefit
- Conversion Privilege
- Dependent Child Dismemberment Benefit
- Felonious Assault
- Newlywed Coverage
- Seat Belt & Air Bag
- Survivor Benefit
- Waiver of Premium

Voluntary Accidental Death

The Hartford – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

When is it effective?

Coverage goes into effect subject to the terms and conditions of the policy. In no case will newly elected benefits become effective sooner than 7/1/2014. You must be Actively at Work with your employer on the day your coverage takes effect.

How much Voluntary Accidental Death and Dismemberment Insurance can I purchase?

You can purchase Voluntary Accidental Death and Dismemberment Insurance in increments of $10,000.

The maximum amount you can purchase cannot be more than 10 times your annual Earnings or $500,000. Earnings are as defined in The Hartford's contract with your employer.

Does my coverage reduce as I get older?

By 65% @ age 70, 45% @ age 75, 30% @ age 80, 15% @ age 85.

Do I have to provide medical information to receive coverage?

No medical information is required. You are guaranteed the amount of coverage that you select, subject to maximum amounts defined in your policy.

What is a beneficiary?

Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.
You are automatically the beneficiary for any dependent coverage and for any AD&D losses other than life.

Voluntary Accidental Death and Dismemberment Insurance for your dependents

If you elect Voluntary Accidental Death and Dismemberment Insurance for yourself, you may also choose Voluntary Accidental Death and Dismemberment Insurance for your Spouse and/or dependent Children. Dependent coverage is available only when you elect coverage for yourself.

You may choose Voluntary Accidental Death and Dismemberment Insurance for your Spouse in the following amounts:

- in increments of $10,000, to a maximum of $500,000.

You may not elect coverage for your Spouse if your Spouse is already covered as an Employee under this policy. Spouse amount cannot exceed 100% of the employee election.

You may choose guaranteed Voluntary Accidental Death and Dismemberment Insurance for each Child up to age 19 (age 24 if a student) in the following amounts:

- in increments of $5,000, to a maximum of $25,000.

Important Details

As is standard with most Insurance, this Voluntary Accidental Death and Dismemberment Insurance includes limitations and exclusions. Voluntary Accidental Death and Dismemberment Insurance does not cover losses caused by or contributed by:

- Sickness; disease; or any treatment for either;
- Any infection, except certain ones caused by an accidental cut or wound;
- Intentionally self-inflicted injury, suicide or suicide attempt;
- War or act of war, whether declared or not;
- Injury sustained while in the armed forces of any country or international authority;
- Taking prescription or illegal drugs unless prescribed for or administered by a licensed physician;
- Injury sustained while committing or attempting to commit a felony;
- The injured person's intoxication.

Other exclusions may apply depending upon the terms of your policy and other requirements. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

This Benefit Highlights Sheet is an overview of the general purposes of the Voluntary Accidental Death and Dismemberment Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the Insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your Insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the policy, the terms of the Insurance policy apply.

Voluntary Short Term Disability

Unum – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

If you're sidelined, will your bank account be disabled?

Help protect your finances with Unum's individual short term disability insurance.

How much is enough for your lifestyle?

Janet has worked hard to grow in her nursing career. She's got a great marriage and a brand new home. Now she wants a baby. She doesn't want to choose between making the house payment and taking maternity leave. She is looking for coverage that will give her the best of both worlds.

My Checklist

Expenses that you may choose to cover with your disability benefits:

- ☐ Mortgage/rent
- ☐ Transportation (gas, car payments, repairs)
- ☐ Utilities (electric, water, cable, Internet)
- ☐ Child care/elder care
- ☐ College expenses
- ☐ Loans/credit card debt

Disability benefits to help keep your account up and running

Individual short term disability insurance can pay you a percentage of your monthly salary if you are injured or ill off-the-job and cannot work due to a disability or covered pregnancy. You can choose monthly benefit amounts from $400 to $5,000. You can use it any way you choose.

Who's at risk?

- Nearly 27 million Americans suffer disabling injuries each year.
- Most disabilities are not work-related, and therefore not covered by workers' compensation.
- 38% of workers could pay their bills for three months of less if they couldn't work due to a disability.

Get the coverage you need.

Individual short term disability insurance is offered to all eligible employees ages 17 to 69 who are actively at work. You decide if it's right for you.

Get the options you need

You can choose from the following options:

Benefit period — If you become disabled, this is the maximum amount of time you can receive benefits for a covered disability.

Elimination period — This is the number of days that must pass between your first day of a covered disability and the day you can begin to accrue your disability benefits.

Benefit amount — Choose a monthly benefit between $400 and $5,000 for an off-the-job illness or injury disability. Coverage of up to 60% of your gross monthly salary may be offered.

Four reasons to buy this coverage at work

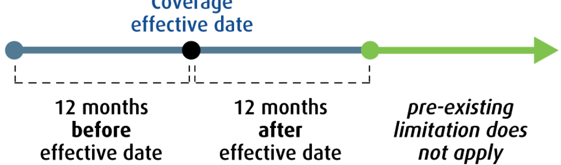
1. You own the policy so you can keep it even if you leave the company or retire. Unum will bill you directly for the same premium amount.
2. Coverage becomes effective on the first day of the month in which payroll deductions begin.
3. Your policy is guaranteed renewable, until age 72, as long as you pay the premiums on time.
4. Affordable premiums are based on your age on the policy effective date and are deducted from your paycheck.

Features that add value

Waiver of premium — Included at no extra charge for covered injuries and illnesses. It means you don't have to pay your premiums after 90 days of total disability or the elimination period (whichever is longer). They'll be waived as long as the disability continues, up to the maximum benefit period.

Policy provisions

Pre-existing condition limitation — If you have a preexisting condition* within a 12-month period before your coverage effective date, benefits will not be paid for a disability period if it begins during the first 12 months the policy is inforce.



*A pre-existing condition is a condition for which symptoms existed (within 12 months before your coverage effective date) that would cause a person to seek treatment from a physician or for which a person was treated or received medical advice from a physician, or took prescribed medicine. The determination on whether your condition qualifies as pre-existing will be based on the date of disability and not the date you notify Unum.

Pregnancy — Nine months after coverage becomes effective, pregnancy is considered the same as any other covered illness. The available monthly benefits will be paid upon fulfillment of the elimination period. Benefits will not be paid if the insured individual gives birth within nine months after the coverage becomes effective. However, medical complications of pregnancy may be considered as any other covered sickness, subject to the pre-existing condition limitation.

My short term disability coverage

Amount I applied for: $________________

Cost per pay period: $________________

Date deductions begin: _____/_____/_____

(For your records — complete during your enrollment)

Refer to the certificate for additional information.

Voluntary Accident Plan

Unum – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

If you have an accident, will it hurt your bank account too?

Unum's accident insurance gives you something to fall back on.

Life can take a tumble.

With a full-time job and three active kids, Marsha has a lot of demands on her time — and her pocketbook. So if her kids break something other than a window, she doesn't want an injury to break her bank account as well.

Benefits that pay for covered accidents while you are on the road to recovery

Unum's coverage provides a lump sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Examples of covered injuries include:

- broken bones
- burns
- torn ligaments
- cuts repaired by stitches
- coma due to a covered injury
- eye injuries
- ruptured discs
- concussion

Some covered expenses include:

- emergency room treatment
- outpatient surgery facility
- doctor's office visit
- hospitalization
- occupational therapy
- speech therapy
- chiropractic visit
- physical therapy

See the schedule of benefits for a full list of covered injuries and expenses.

Who's at risk?

- Every 10 minutes almost 740 people will suffer disabling injuries in the United States.[1]
- About two-thirds of disabling injuries suffered by American workers are not work-related, and therefore not covered by workers' compensation.[2]

Get the coverage you need.

Choose the coverage that's right for you. Your accident insurance plan can provide benefits for covered accidents that occur on and off the job. Accident insurance is offered to all eligible employees who are actively at work. You decide if it's right for you and your family.

The following benefits are automatically included in your plan:

Wellness Benefit
Based on the plan selected by your employer, this benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including:

- Blood tests
- Stress tests
- Colonoscopies
- Chest X-rays
- Mammograms

There is an additional charge for this feature. A full list of covered tests will be provided in your certificate.

Catastrophic Benefit
This pays an additional sum if a covered individual has a serious injury — such as loss of sight, hearing or a limb — before age 65.

Four reasons to buy this coverage at work:

1. No health questions to answer. If you apply, you automatically receive this base plan.
2. This plan is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly for the same premium amount.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.
4. Premiums are conveniently deducted from your paycheck.

Voluntary Accident Plan

Unum – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

Additional coverage options

Sickness Hospital Confinement Benefit — Depending on your plan, your employer may have chosen to include this benefit — or you may have the option to select it. This option pays the insured employee, spouse or children a daily benefit if he or she is in the hospital for a covered illness. Based on the plan your employer selects, the amount you receive can be $100 per day. Children's coverage pays 75% of the employee amount.

This benefit is available to family members who are covered by the base plan. There is an additional charge for this feature.

The benefit includes a 12-month pre-existing condition limitation and may vary by state. Employees and their spouses need to answer certain health questions when applying for this benefit.

Available family coverage

Who can have it?	
Spouse coverage	Ages 17 to 64
Child coverage	Dependent children newborn until their 26th birthday, regardless of marital or student status.[3]

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must live in the U.S. to receive coverage.

An illustrative example of how accident coverage can help you with your expenses*

40-year-old claimant

Accident: Fall at home
Injury: Broken toe and ACL tear (knee ligament injury)

Out-of-pocket expenses incurred:
- $100 emergency room copay
- $500 deductible
- $750 copay for surgery ($3,750 x 20%)
- $150 copay for 10 physical therapy visits

Total out-of-pocket expenses: $1,500

Benefits paid:
- $150 emergency room visit
- $100 appliance (knee brace)
- $150 fractured toe
- $800 surgical ligament tear repair
- $ 75 follow-up appointment
- $150 for six physical therapy sessions

Total benefit paid under policy: $1,425

* Costs of treatment and benefit amounts may vary. Example is based on the level 2 schedule of benefits.

My accident coverage

Coverage plan chosen: $________________

Cost per pay period: $________________

Date deductions begin: _____/_____/_____

(For your records — complete during your enrollment)

[1, 2] National Safety Council, "Injury Facts," 2011 edition.
[3] In GA, IL and ND, child coverage is available newborn until their 27th birthday.

Voluntary Critical Illness

Unum – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

Could your bank account survive a serious illness?

Get protected with group critical illness insurance from Unum.

Lisa's story

Lisa was planning her daughter's wedding when a stroke disrupted her plans. Thanks to her critical illness coverage, Lisa was able to afford the treatment her medical insurance didn't cover. So she was able to focus on her goal for recovery: to dance at her daughter's wedding.

Who's at risk?

- The risk of developing cancer during a lifetime is nearly one in two for men and more than one in three for women.[1]
- Every 40 seconds someone in America will have a stroke.[2]

Key advantage

You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. The diagnosis of a new covered illness must occur at least 90 days after the most recent diagnosis and be medically unrelated. Each condition is payable once per lifetime.

Three reasons to buy this coverage at work

1. You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.
2. Coverage is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly for the same premium amount.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.

How can critical illness insurance help?

Critical illness insurance can pay a lump sum benefit at the diagnosis of a covered illness. You choose the level of coverage — from $5,000 to $50,000 — and you can use the money any way you see fit.

Covered conditions	
Heart attack	Blindness
Major organ failure	End-stage renal (kidney) failure
Occupational HIV	Coronary artery bypass surgery; pays 25% of lump sum benefit
Benign brain tumor	
Covered conditions with time limitations	
Stroke	Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event
Coma	Coma resulting from severe traumatic brain injury lasting for a period of 14 or more consecutive days
Permanent paralysis	Complete and permanent loss of the use of two or more limbs for continuous 90 days as a result of a covered accident
Optional cancer conditions	
If selected by your employer, you may choose to select this benefit for an additional premium.	
Cancer	Carcinoma in situ;[3] pays 25% of lump sum benefit

Please see policy definitions for complete details about these covered conditions.

Voluntary Critical Illness

Unum – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP

Group critical illness insurance

The following benefit is automatically included in your plan:

Wellness benefit

Based on the plan selected by your employer, this benefit can pay $50 per calendar[4] year per insured individual if a covered health screening test is performed, including:

- Blood tests
- Colonoscopies
- Mammograms[5]
- Stress tests
- Chest X-rays

If you have other policies with a wellness benefit feature, you can receive a total of one benefit payment per year. A full list of covered tests will be provided in your certificate.

Provisions

Reduction of benefits

The benefit amount for the employee and spouse reduces by 50% on the first policy anniversary date after the insured individual's 70th birthday. Premiums will not be reduced. For coverage purchased after age 70, benefit amounts will not be reduced.

Available family coverage

Who can have it?	Benefit
Employees who are actively at work	$5,000 to $50,000 in $1,000 increments
Dependent children newborn until their 26th birthday, regardless of marital or student status All eligible children are automatically covered at 25% of the employee benefit amount (no additional cost)	Eligible children are covered for the same conditions as employee and the following specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. Diagnosis must occur after the child's coverage effective date.
Spouse ages 17 through 64 with purchase of employee coverage*	From $5,000 to $30,000 in $1,000 increments

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must live in the U.S. to receive coverage.

* Employees and spouses may be covered under a policy or the Spouse Rider, but not both.

My critical illness coverage

Amount I applied for: $_______________

Cost per pay period: $_______________

Date deductions begin: _____/_____/_____

(For your records — complete during your enrollment)

[1] American Cancer Society, "Cancer Facts & Figures," 2012.
[2] The American Heart Association, "Heart Disease and Stroke Statistics—2012 Update," 2012.
[3] Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.
[4] In WA, the wellness benefit is $75.
[5] In CA, the mammography benefit may be payable based on the exam schedule defined in the policy. In MT, the mammography benefit is paid under the cancer benefit.

Whole Life

Unum

Whole Life

Coverage that can last a lifetime.

Will your family have a picture-perfect lifestyle if you're out of the picture? Unum's interest sensitive whole life insurance can help. Whether the policy is used to supplement term life insurance or purchased as a stand-alone product, whole life insurance plays a vital role in securing your family's financial future.

Interest Sensitive Whole Life Insurance Coverage

- **Level Premium –** Premium rates do not increase as you get older.
- **Level Death Benefit –** Death benefit does not reduce as you get older.
- **Cash Value with 4.5% Guaranteed Interest Rate –** The "cash value," or equity of the policy builds at an interest rate guaranteed to be at least 4.5%.
- **Long-Term Care Benefit included –** Access 100% of the death benefit for Long-Term Care needs (paid out evenly over the course of 16-25 months).
  - o **Continuation Rider** available that will double the Long-Term Care benefit duration (paid out evenly over the course of 32-50 months)
  - o **Restoration Rider** available (After death benefit has exhausted due to Long-Term Care benefits, this rider restores 100% of death benefit)
  - o **Continuation/Restoration Combination Rider** available
- **Fully Paid-Up Option at Age 70 (issue ages 15-50) –** You can exercise a "paid-up" option at a future time if desired.
- **100% Portable –** You can take this policy with you at the exact same premiums if you leave or retire from your company.
- **Stand-alone Coverage for Spouse, Children and even Grandchildren –** You do not have to purchase coverage on yourself as an employee in order to elect coverage on an eligible family member.

How long do you want your life insurance to last?

Everyone's life insurance needs are different, particularly throughout the different stages of life. Whether you are single and just starting your career, married and have increasing family obligations or getting close to retirement, life insurance is an important financial consideration to help you plan for the future.

Sample Rates

Face amounts based on $5 per week		
Issue Age	Non-Tobacco	Tobacco
25	$29,851	$17,128
35	$19,417	$11,786
45	$11,581	$6,835
55	$6,066	$3,636
65	$2,943	$2,066

Face amounts based on $10 per week		
Issue Age	Non-Tobacco	Tobacco
25	$59,701	$34,256
35	$38,835	$23,572
45	$23,163	$13,670
55	$12,133	$7,273
65	$5,885	$4,133

Defined Contribution Retirement Plan

Welcome to the Adventist Retirement Defined Contribution Plan, where retirement planning starts today to cover your tomorrows.

Whether you are just beginning or already well into your career, now is the time to begin planning for your future. The Adventist Retirement Plan (ARP) and VALIC have joined forces to provide you with the tools and resources to help you develop a retirement package that may meet your financial needs for the future. Here are some of the tools that are available to you:

1. www.valic.com/adventist, providing secure 24-hour Internet access to your account and investment information.
2. Easy access at 888-568-2542, a phone automated information service providing you with the same easy-to-use account services as the Web site.
3. A quarterly statement will be sent to keep you up-to-date on your portfolio's progress.

Please read carefully any materials regarding retirement that you have received and contact VALIC Retirement to arrange a one-on-one meeting with a financial professional. They will be happy to answer your questions and work with you to develop an investment strategy that will meet your retirement needs. The VALIC Retirement Financial Advisor in this area is Casey Quinn, whose contact information follows:

Casey Quinn
Email: casey.quinn@valic.com
Work/Cell Phone: 248-326-8538
www.valic.com

To activate or change your contribution rate, you may do so online at www.andrews.edu/go/mybenefits. Once logged in using your Andrews University Username and Password, click on this link to open a PDF of step-by-step instructions. Retirement Election Instructions

Employee Base	5.00%
Employee Voluntary	3.00%
Employer Match (max)	3.00%
Total	11.00%

Tuition Assistance for Dependent Children

AF/SA/SF/FA/FF/FT/HF

If you are a full-time regular employee and have unmarried, dependent children who are less than twenty-four years of age attending school, the following policy applies to you. (Exceptions may be made to the age requirement if education has been interrupted due to compulsory military service, volunteer service for the church, or a documented medical condition.)

Educational scholarship assistance in the form of tuition grants is available upon application, for unmarried dependent children of a full-time regular University employee.

Scholarship Grants are computed as follows:

- For Hourly employees, thirty-five percent of basic tuition costs for the child(ren) attending a Lake Union Conference SDA elementary or day academy, or in an undergraduate program of Andrews University as a day/village student.
- For Salaried, thirty-five percent of basic tuition costs for the child(ren) attending a Lake Union Conference SDA elementary or day academy, or in an undergraduate program of Andrews University as a day student, or in an undergraduate program at other North American Division SDA schools.
- Sixty percent of basic tuition costs for child(ren) enrolled as boarding student(s) at a Lake Union Conference SDA academy or in an undergraduate program at Andrews University.

Tuition assistance shall be provided through Home Study International or credits that are earned through the College Level Examination Program (CLEP). The assistance on both is 35% whether or not the student is residing in a school dormitory.

The amount of the grant will be based on the actual tuition costs and general fees when charged separately, and does not include charges for special music lessons. Fees for required music lessons may be included for music majors or minors.

Assistance may continue until an undergraduate program is completed, or for a maximum of ten semesters of undergraduate study, whichever comes first. Attendance at summer sessions count against the maximum semesters.

Assistance may be available for the child(ren) who enters a professional program in medicine or dentistry prior to completing undergraduate degree requirements. The

assistance will not be available for a period longer than that which would have been required to complete the undergraduate degree nor for more dollars than would have been allowed as a full-time undergraduate student at Andrews University.

Grants shall be available for the child(ren) of the employee who is employed at the beginning of the child(rens') school year and scholarships will be prorated if the individual is employed after the beginning of the school year. It is understood that the child(ren) must be in school at the time for which the scholarship is paid. The scholarship shall be credited to the student's account each semester when bills are presented.

Free Class

AF/SA/SF/FA/FF/FT/HF

For Employees: Full-time regular staff members may take up to four credits each semester without cost to themselves. Normally, the class must be outside of regular scheduled work hours. Employees are not paid for the time they are attending class.

For Employees' Spouse: The spouse of a salaried full-time regular staff member (Class AF, SA, SF, FA, FF, FT, or HF) may receive assistance through the Master's level. Assistance is up to four credits free plus 50% of the tuition on classes in excess of four credits each semester.

Please contact the Benefits Office on how to apply for a Free Class and for full details on how the Free Class Benefit is processed. Certain restrictions and guidelines apply.

Paid Time Off – Salary/Faculty

The Andrews University Vacation Plan is available to workers who are of an AF, AP, SA, SF, SP, FA, FF, FT, or FP classification.

On a pro-rated basis according to your appointment percentage. Annual vacation is based on a full year of service and consists of:

During the first four years of service: 2 weeks
During the next five years of service: 3 weeks
After the ninth year of service: 4 weeks

The length of your vacation week is equivalent to that of your work week. For example, if your work week is Monday to Friday and you took Friday off for vacation, you would have used one fifth of your vacation week.

Paid Time Off - Hourly

The Andrews University Paid Leave Plan is available to workers who are of an HH, HF, or HP classification.

The purpose of the plan is to provide a continuity of income during specific periods of absence which includes vacation, personal time, holidays and short-term sick leave and medical/vision/dental appointments.

Accrual Rate - Time begins to accrue on the first day of employment at the following rate, as determined by total denominational employment: (The leave bank illustration is based on a 40-hour work week.)

	Total Hours	Equivalent Days	Maximum Annual Accrual	Hourly Rate of Accrual
One through four years	0 - 7,488	25	200 hours	0.0961538
Five through nine years	7,489 to 16,848	30	240 hours	0.1153846
Starting tenth year	Begin 16,849	35	280 hours	0.1346153

Except for holidays and sick leave, the Paid Leave Bank may be used at the discretion of the employee upon prior arrangement with the department head.

Time in the Paid Leave Bank may be paid only when the employee is off duty during his/her normal working hours, except at the time of termination or retirement.

Time in the Paid Leave Bank accrues only on the first 80 hours of paid time in a two-week pay period.

The University recognizes eight holidays, two of which are a day-and-a-half for a total of nine days annually. The holidays are:

- New Year's Day
- Martin Luther King's Birthday
- Presidents' Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving (1.5)
- Christmas (1.5)

Anesthesiology, Pathology or Radiology Charges

If a covered person receives eligible treatment at an in-network facility, any anesthesiology, pathology, or radiology charges will be paid at the in-network benefit percentage, even if out-of-network providers performed those services. However, charges in excess of the usual and customary limitation will not be eligible under the Plan. Additionally, this practice of paying in-network-level benefits for services rendered by out-of-network providers may be expanded in certain situations if the proper referral procedures have been followed. Any such referrals must be approved by the Utilization Review Firm. Please see the Utilization of In-Network Providers section of the Plan document for additional information.

Alternative Treatment

The description of covered expenses under the Plan may be expanded in certain situations in order to provide the most appropriate and cost-effective level of care for the covered person. These alternative treatment benefits may be provided after review and consultation with both the Utilization Review Firm and the covered person's physician. Each situation shall be reviewed, and recommendations made, on a case-by-case basis. The Utilization Review Firm cannot require a change in a covered person's level of care without the approval of the attending physician. After alternative treatment is initiated, the Utilization Review Firm shall monitor the care to ensure that the most appropriate level of care is maintained. This provision shall not increase any stated maximum benefit described in the Schedule of Benefits.

Global Healthcare Benefit

A hospital or facility outside of the United States that is accredited by the Joint Commission International (JCI) and any providers with privileges at such a hospital or facility shall all be considered eligible in-network providers under the Plan for cost-effective and medically necessary treatment of an illness or injury. Eligible charges for necessary transportation to and from a JCI-accredited hospital or facility and charges for the diagnosis and treatment of an illness or injury shall be paid in the same manner as in-network medical or surgical benefit in terms of the Plan's financial requirements (deductible, benefit percentage, etc.). The Plan's normal usual and customary fee limitations will not apply to services billed by JCI-accredited hospital or facility or any providers with privileges at such a hospital or facility.

A covered person who is considering having services performed at a JCI-accredited hospital or facility is strongly encouraged to contact the Utilization Review Firm by calling the number on the front of his or her health plan identification card. The Utilization Review Firm will review the treatment plan and, if no issues are identified, will refer the covered person to the Plan's international health management company. The Plan's international health management company will help the covered person locate a JCI-accredited hospital or facility that can perform the proposed services and will also determine whether it is cost effective to have the proposed services (including related expenses for travel and lodging) performed at that hospital or facility rather than by in-network providers.

If the Plan's international health management company determines that it is not cost effective to have the proposed services (including related expenses for travel and lodging) performed at the JCI-accredited hospital or facility, **all related expenses may be ineligible under the Plan if the covered person proceeds to have the services performed at the JCI-accredited hospital or facility outside of the United States. See the Plan Document/SPD for additional information**.

Traveling on AU Business

If a Participant receives treatment from an out-of-network provider while traveling on Andrews University business, all eligible claims will be paid at the in-network level.

Motor Vehicle Exclusion (Michigan Residents Only)

Benefits are not payable under this plan for injuries received in an accident involving a motor vehicle as defined in the plan. It is your responsibility to obtain proper motor vehicle insurance that will give you and your family medical benefits. If you fail to maintain your motor vehicle insurance, you will not have any medical expense coverage for auto-related injuries. This exclusion shall not apply to a covered person who is a Michigan resident involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion shall apply if a covered person is injured while in his or her own uninsured motor vehicle for which a Michigan no-fault policy is legally required and would have provided coverage, had such a policy been in effect.

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents (Non-Michigan Residents Only)

In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary Plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Special Provision for Spouses Employed Full-Time

A participant's spouse who is eligible for coverage under his or her own employer's group health plan as a full-time employee will not be eligible to participate in or be covered under our Medical/RX Plan. A Participant's spouse who is eligible for coverage under his or her own employer's group health plan as a part-time employee will not be subject to this provision. A participant or spouse who is an employee of Andrews University and who is married to an individual who is also an employee of Andrews University will also not be subject to this provision and will not be penalized for declining to enroll separately as individual participants in this Plan.

The participant is obligated to immediately report to the Plan Administrator any change that would affect his or her spouse's eligibility under this Plan (i.e., the spouse changes employers or the spouse's employer offers its employees a health plan for the first time). If it is found that a spouse who is eligible for coverage under his or her own employer's group health plan as a full-time employee has not enrolled for his or her own employer's group health plan as required by this provision, benefits for the spouse may be terminated. Coverage may not be retroactively rescinded except as permitted by law, for example, in cases of fraud or intentional misrepresentation. Notice that coverage will be retroactively rescinded must be provided 30 days before proceeding with the termination process.

Acquisition of Personal Information

We collect nonpublic personal information about the individual participants of group plans, which the employers/plan sponsors and health care providers afford us.

Categories of Information We Disclose

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. For example, we only disclose nonpublic personal information when it is related to a request or transaction from the employer/plan sponsor, where authorized by the participant, or where required by law.

Parties to Whom We Disclose Information

We only permit disclosure of nonpublic personal information to our employees who are working on clients' accounts and to unrelated third parties who need to know that information in order to assist us in providing services to clients.

Confidentiality and Security of Nonpublic Personal Information

We restrict access to nonpublic personal information to those individuals who need to know that information in order to provide services or products for the policy. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to secure nonpublic personal information.

Women's Health and Cancer Rights Act of 1998 (also known as "Janet's Law")

Did you know that your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services? These services include reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema). Call your Claim Administrator at (616) 957-1751 or 1-800-968-2449 for more information.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or a Children's Health Insurance Program (CHIP), and you are eligible for health coverage from your employer, your state may have a premium-assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP to help people who are eligible for these programs but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or a CHIP, you will not be eligible for these premium-assistance programs. If you or your dependents are already enrolled in Medicaid or a CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or a CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office, dial 1-877-KIDS NOW, or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or a CHIP and are eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This situation is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor via its Website at www.askebsa.dol.gov or by calling toll-free at 1-866-444-EBSA (3272). If you live in Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, or Wyoming, you may be eligible for assistance paying your employer health plan premiums. You should contact your state for further information on eligibility.

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either of the following entities:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Notes

Resources

Type of Question	Contact Information
Andrews University Benefits Office	T: 269.471.3886 www.andrews.edu/hr
Copies of Plan Summaries and/or Plan Documents	www.andrews.edu/go/mybenefits
Eligibility bswift	 T: 866.365.2413 ext. 6208
Medical/Vision/Dental Plan PhysiciansCare (ASR Health Benefits) Medical/dental/vision claims, coverage, find a physican	T: 800.968.3033 F: 616.464.4458 www.asrhealthbenefits.com
Flexible Spending Accounts PhysiciansCare (ASR Health Benefits)	T: 800.968.3033 F: 616.464.4458 www.asrhealthbenefits.com
Networks While Traveling CIGNA Network Multiplan	 www.cigna.com www.multiplan.com
Pharmaceutical Plan Navitus WellDyneRx (Mail Order)	 T: 866.333.2757 www.navitus.com T: 866.490.3326
Retirement Valic	Casey Quinn T: 248.326.8538 casey.quinn@valic.com
Unum Voluntary Short Term Disability	T: 800.635.5597 www.unum.com/groupaccident
Whole Life (LTC) worksite products: Unum	 T: 800.635.5597 www.unum.com/employees
Supplemental Life Insurance Hartford Group Benefits *(Contact AU Benefits Office)*	 T: 800.523.2233
Accidental Death & Dismemberment Hartford Group Benefits *(Contact AU Benefits Office)*	 T: 800.523.2233
Auto Insurance Liberty Mutual	Neal Boff T: 269.327.2600 ext. 5071 neil.boff@libertymutual.com
Adventist Risk Management Short Term Travel	 T: 888.951.4ARM (4276)
Tuition Assistance	T: 269.471.3886
Free Class	T: 269.471.3886
Identity Theft Protection	T: 877.890.0240
Employee Travel Assistance Program	T: 800.243.1528

This guide is designed as a reference to help eligible members enroll for benefits and answer many of the questions you might have about benefits during the year. The legal documents and insurance contracts governing these plans will determine your benefits in the events of any omissions or discrepancies. Your participation in these plans is not a contract of employment and does not guarantee your future employment. Andrews University reserves the right to change or end any of the plans, at any time and for any reason, to the extent allowed by law. 2014-2015.