ASR health benefits

Andrews University, G-773

Benefit Description	Premier Plan		Standard Plan		High Deductible Health Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Benefit Year	July 1 through June 30		July 1 through June 30		July 1 through June 30	
Deductible per Benefit Year	$500/person $1,000/family	$3,000/person $6,000/family	$650/person $1,300/family	$3,000/person $6,000/family	$1,450/single $2,900/family	$3,000/single $6,000/family
	Special Note About the Benefit Year Deductible: An individual within a family has to meet only the per person deductible specified above before the Plan will begin paying benefits. 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.		**Special Note About the Benefit Year Deductible:** An individual within a family has to meet only the per person deductible specified above before the Plan will begin paying benefits. 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.		**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	90% after deductible (10% coinsurance)	60% after deductible (40% coinsurance)	80% after deductible (20% coinsurance)	60% after deductible (40% coinsurance)	80% after deductible (20% 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*	$3,700/person* $7,400/family*	$5,000/person* $10,000/family*	Not applicable to this plan option; refer to the Total Maximum Out-of-Pocket stated below	
	*An individual within a family has to meet only the per-person Coinsurance Maximum Out-of-Pocket before the Plan's benefits will increase to 100%. 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.		*An individual within a family has to meet only the per-person Coinsurance Maximum Out-of-Pocket before the Plan's benefits will increase to 100%. 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	$4,350/person** $8,700/family**	Not applicable	$5,350/person** $10,700/family**	Not applicable	$3,250/single* $6,500/family*	$8,000/single* $16,000/family*
	**Includes deductible, coinsurance, and medical co-payments. 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. An individual within a family has to meet only the per-person Total Maximum Out-of-Pocket before the medical co-payments will no longer be charged for the remainder of the benefit year. Prescription drug co-payments track toward a separate Prescription Drug Maximum Out-of-Pocket to the extent required by Health Care Reform (see the separate Prescription Drug Benefit summary for more information).		**Includes deductible, coinsurance, and medical co-payments. 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. An individual within a family has to meet only the per-person Total Maximum Out-of-Pocket before the medical co-payments will no longer be charged for the remainder of the benefit year. Prescription drug co-payments track toward a separate Prescription Drug Maximum Out-of-Pocket to the extent required by Health Care Reform (see the separate Prescription Drug Benefit summary for more information).		*Includes deductible, coinsurance, and co-payments (if applicable). 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. All co-payments, including prescription drug co-payments (if any), specified below will no longer apply once the Total Maximum Out-of-Pocket is satisfied in a Benefit Year. 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%.	

Benefit Description	Premier Plan		Standard Plan		High Deductible Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum Paid per Covered Person per Benefit Year for All Covered Expenses	Unlimited		Unlimited		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	$30 co-payment per visit, then 100% (deductible waived)	60% after deductible	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	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	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	100%; deductible waived	Not covered	100%; deductible waived	Not covered
Emergency Room Treatment						
Physician's Fee for an Examination in the Emergency Room	90% after deductible	Paid as in-network	80% after deductible	Paid as in-network	80% 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	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	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 (waived if admitted), then 100% (deductible waived)	Paid as in-network	$250 co-payment per visit (waived if admitted), then 100% (deductible waived)	Paid as in-network	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	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% 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	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	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

Benefit Description	Premier Plan		Standard Plan		High Deductible Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Authorization Requirement $250 Penalty for Non-Compliance	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 Oncology treatment					
Inpatient Hospital Services Room and Board, Surgical Services, and Ancillary Services	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient Physician Services Hospital Visits, Surgical Procedures, and Anesthesiology	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
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	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Diagnostic X-Ray and Lab Test Services	100% after deductible	60% after deductible	100% after deductible	60% after deductible	80% after deductible	60% after deductible
Pre-Admission Testing	100% after deductible	60% after deductible	100% after deductible	60% after deductible	80% after deductible	60% after deductible
Allergy Services Injections and Serum Allergy Testing	90% after deductible 100% after deductible	60% after deductible 60% after deductible	80% after deductible 100% after deductible	60% after deductible 60% after deductible	80% after deductible 80% after deductible	60% after deductible 60% after deductible
Chiropractic Care Spinal Manipulations and Therapy Treatments Diagnostic Spinal X-Rays Physician's Fee for an Initial or Periodic Evaluation $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)	100%; deductible waived 100%; deductible waived $20 co-payment per visit, then 100% (deductible waived)	100%; deductible waived 100%; deductible waived $20 co-payment per visit, then 100% (deductible waived)	100%; deductible waived 100%; deductible waived $30 co-payment per visit, then 100% (deductible waived)	100%; deductible waived 100%; deductible waived $30 co-payment per visit, then 100% (deductible waived)	80% after deductible 80% after deductible 80% after deductible	Paid as in-network Paid as in-network Paid as in-network
Massage Therapy (Medically Necessary Services Only) $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)	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible

Benefit Description	Premier Plan		Standard Plan		High Deductible Health Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Rehabilitative Therapy Physical Therapy, Speech Therapy, and Occupational Therapy	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment, Prosthetics, and Orthotics	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hearing Services Hearing Exams	$20 co-payment per visit, then 100% (deductible waived)	Not covered	$30 co-payment per visit, then 100% (deductible waived)	Not covered	80% after deductible	Not covered
Hearing Testing	90% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	Not covered
Hearing Aids	75% after deductible	Not covered	75% after deductible	Not covered	75% after deductible	Not covered
Behavioral Care (Includes Mental Health Care and Addictions Treatment) Inpatient/Partial Hospitalization Services Outpatient/Intensive Outpatient Services	Paid the same as any other illness; however, any applicable co-payment typically applied to an inpatient hospital admission will be waived		Paid the same as any other illness; however, any applicable co-payment typically applied to an inpatient hospital admission will be waived		Paid the same as any other illness	
Infertility Treatment $3,000 Lifetime Maximum Paid per Covered Person for All Eligible Infertility Treatment (In-Network Services Only)	60% after deductible	Not covered	60% after deductible	Not covered	60% after deductible	Not covered
Special Note about Infertility Treatment Eligible prescription drugs prescribed for the treatment of infertility are not covered under this benefit, but may be eligible for coverage under the Plan's Prescription Drug benefit.						
Temporomandibular Joint Dysfunction (TMJ) Treatment $500 Lifetime Maximum Paid per Covered Person for All Non-Surgical TMJ Treatment (In-Network and Out-of-Network Services Combined); The Plan Will Also Allow Charges for Surgery if All Other Means of Generally Accepted Treatment Have Been Exhausted.	Paid the same as any other illness		Paid the same as any other illness		Paid the same as any other illness	
Convalescent Care and Home Health Care	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospice	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible

Miscellaneous Plan Provisions

Services Requiring Authorization:

1. Inpatient hospital confinements and observational stays
2. Home and outpatient rehabilitative therapy
3. Rental and purchase of durable medical equipment
4. Home health care
5. Purchase of custom-made orthotic or prosthetic appliances
6. Oncology treatment

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.

If a covered person receives treatment from an out-of-network provider and the Plan Administrator determines that treatment was not provided by an in-network provider because a covered person traveled to a place where he or she could not reasonably be expected to know the location of the nearest in-network provider (if available), the claim may be adjusted to yield in-network-level benefits.

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.

NOTE: If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact ASR Health Benefits at (800) 968-2449.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact ASR Health Benefits at (800) 968-2449.

Special Eligibility Provision for Spouses Employed Full-Time

A participant's spouse who is eligible for coverage under his or her own employer's group medical plan as a full-time employee will not be eligible to participate in or be covered under 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 medical 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 medical plan as a full-time employee has not enrolled for his or her own employer's group medical plan as required by this provision, benefits for the spouse may be terminated. Coverage may not be retroactively rescinded except as permitted by law (e.g., 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. Otherwise, coverage will be terminated prospectively once the error is discovered.

The following exceptions to this provision shall apply:

- A participant's spouse who is eligible for coverage under his or her own employer's group medical plan as a part-time employee is not required to enroll for that coverage in order to be covered under this Plan.
- This provision does not apply to dental or vision benefits offered under the Plan. Any spouse may enroll for the Plan's dental or vision benefits even if he or she is eligible for dental or vision coverage under his or her own employer's group health plan.
- 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 not be subject to this provision and will not be penalized for declining to enroll separately as individual participants in this Plan.
- In certain limited situations, Andrews University may deem that a spouse's employer-provided group medical plan fails to meet the University's criteria for a "medical plan" for the purposes of this special eligibility provision. In such cases, the spouse may then enroll for the Plan's medical benefits and he or she will not be required to elect his or her own employer's group medical plan. If your spouse's employer-provided group medical plan provides only limited or supplemental coverage for health-related expenses, please contact the Andrews University Human Resources Department for additional information about whether or not your spouse may enroll in the Plan.

Benefit Description	Premier Plan Prescription Drug Benefit Description
Prescription Drugs Retail Prescription Drug Co-payments (30-Day Supply) A covered person is able to purchase a 31- to 90-day supply of an eligible medication at a retail pharmacy for the applicable mail-order co-payment stated below. A physician's prescription for the greater day supply is required.	$-0-/for prescription of Claritin available over-the-counter or Prilosec OTC, $10/Formulary preferred generic drugs, $20/Formulary non-preferred generic drugs, $50/Formulary preferred brand-name drugs, $70/Formulary non-preferred brand-name drugs
Mail-Order Prescription Drug Co-payments (90-Day Supply) Eligible prescription drugs will be subject to the applicable retail prescription drug co-payments stated above if dispensed in a 30-day supply (or less) through the Mail-Order Program.	$-0-/for prescription of Claritin available over-the-counter or Prilosec OTC, $25/Formulary preferred generic drugs, $50/Formulary non-preferred generic drugs, $125/Formulary preferred brand-name drugs, $175/Formulary non-preferred brand-name drugs
Specialty Prescription Drug Co-payment (30-Day Supply) Drugs classified by the PBM as "Specialty Drugs" must be filled through Lumicera Health Services specialty pharmacy or else that drug purchase will not be eligible for coverage under the Plan.	$150/Specialty drugs
Prescription Drug Maximum Out-of-Pocket per Benefit Year	$2,500/person* $5,000/family*

*Includes prescription drug co-payments only. Does not include amounts attributed to the Total Maximum Out-of-Pocket for medical services, any optional additional amount that the covered person must pay over and above the co-payment, or the cost of any drug or service that is not covered under the Plan.

Special Notes about Prescription Drug Coverage:

1. Generic drugs will be dispensed unless a generic equivalent is not available. If an available generic equivalent is refused, even if the prescribing physician has requested "Dispense as Written" (DAW), the covered person will be required to pay the brand co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.
2. As used in this benefit, the term "preferred generic drug" means the preferred generic drug list maintained by the Pharmacy Benefits Manager (PBM). These drugs generally have a purchase price that is under $50.
3. 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.
4. Prescription drugs 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, lifetime.
5. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications, including, but not limited to, certain FDA-approved contraceptive agents and smoking cessation products with a prescription, as well as breast cancer medications that lower the risk of cancer or slow its development, without any cost-sharing provisions such as deductibles or co-payments. For more information about eligible preventive care medications, the covered person can contact the PBM using the information listed on the front of his/her identification card.
6. As used in this benefit, the term "specialty prescription drug" means a drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty prescription drugs may be injectable medications, high-cost medications, or have special delivery and storage requirements (e.g., they may require refrigeration). Specialty prescription drug purchases will be limited to a 30-day supply, and prescriptions for such drugs must generally be filled through Lumicera Health Services specialty pharmacy or the drug will not be eligible for coverage under the Plan. For additional information about specialty prescription drugs, including information about which drugs are currently on the PBM's specialty prescription drug list, the Covered Person can contact the PBM using the information listed on the front of his/her identification card.
7. Unless specifically noted otherwise, prescription drugs that are not on the formulary drug list maintained by the PBM are not eligible for coverage under the Plan. If a covered person is using an excluded medication under the PBM's formulary list, he or she should speak to a physician to determine if there is an alternative therapy that provides the same therapeutic efficacy. Covered persons can contact the PBM using the phone number on the front of their identification cards for additional information about the coverage status of a particular drug.

Benefit Description	Standard Plan Prescription Drug Benefit Description
Prescription Drugs Retail Prescription Drug Co-payments (30-Day Supply) A covered person is able to purchase a 31- to 90-day supply of an eligible medication at a retail pharmacy for the applicable mail-order co-payment stated below. A physician's prescription for the greater day supply is required.	$-0-/for prescription of Claritin available over-the-counter or Prilosec OTC, $10/Formulary preferred generic drugs, $20/Formulary non-preferred generic drugs, $60/Formulary preferred brand-name drugs, $80/Formulary non-preferred brand-name drugs
Mail-Order Prescription Drug Co-payments (90-Day Supply) Eligible prescription drugs will be subject to the applicable retail prescription drug co-payments stated above if dispensed in a 30-day supply (or less) through the Mail-Order Program.	$-0-/for prescription of Claritin available over-the-counter or Prilosec OTC, $25/Formulary preferred generic drugs, $50/Formulary non-preferred generic drugs, $150/Formulary preferred brand-name drugs, $200/Formulary non-preferred brand-name drugs

Benefit Description	Standard Plan Prescription Drug Benefit Description
Prescription Drugs, cont. Specialty Prescription Drug Co-payment (30-Day Supply) Drugs classified by the PBM as "Specialty Drugs" must be filled through Lumicera Health Services specialty pharmacy or else that drug purchase will not be eligible for coverage under the Plan.	$200/Specialty drugs
Prescription Drug Maximum Out-of-Pocket per Benefit Year	$1,500/person* $3,000/family*
*Includes prescription drug co-payments only. Does not include amounts attributed to the Total Maximum Out-of-Pocket for medical services, any optional additional amount that the covered person must pay over and above the co-payment, or the cost of any drug or service that is not covered under the Plan.	
Special Notes about Prescription Drug Coverage: 1. Generic drugs will be dispensed unless a generic equivalent is not available. If an available generic equivalent is refused, even if the prescribing physician has requested "Dispense as Written" (DAW), the covered person will be required to pay the brand co-payment **plus** the difference in price between the brand-name drug and its generic equivalent. 2. As used in this benefit, the term "preferred generic drug" means the preferred generic drug list maintained by the Pharmacy Benefits Manager (PBM). These drugs generally have a purchase price that is under $50. 3. 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. 4. Prescription drugs 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, lifetime. 5. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications, including, but not limited to, certain FDA-approved contraceptive agents and smoking cessation products with a prescription, as well as breast cancer medications that lower the risk of cancer or slow its development, without any cost-sharing provisions such as deductibles or co-payments. For more information about eligible preventive care medications, the covered person can contact the PBM using the information listed on the front of his/her identification card. 6. As used in this benefit, the term "specialty prescription drug" means a drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty prescription drugs may be injectable medications, high-cost medications, or have special delivery and storage requirements (e.g., they may require refrigeration). Specialty prescription drug purchases will be limited to a 30-day supply, and prescriptions for such drugs must generally be filled through Lumicera Health Services specialty pharmacy or the drug will not be eligible for coverage under the Plan. For additional information about specialty prescription drugs, including information about which drugs are currently on the PBM's specialty prescription drug list, the Covered Person can contact the PBM using the information listed on the front of his/her identification card. 7. Unless specifically noted otherwise, prescription drugs that are not on the formulary drug list maintained by the PBM are not eligible for coverage under the Plan. If a covered person is using an excluded medication under the PBM's formulary list, he or she should speak to a physician to determine if there is an alternative therapy that provides the same therapeutic efficacy. Covered persons can contact the PBM using the phone number on the front of their identification cards for additional information about the coverage status of a particular drug.	

Benefit Description	High Deductible Health Plan Prescription Drug Benefit Description
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, whether the drug is brand-name or generic, 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/Formulary prescription drug
· Mail-Order Prescription Drug Co-payments (90-Day Supply)	20% of the purchase price/Formulary prescription drug
· Specialty Prescription Drug Co-payment (30-Day Supply) Drugs classified by the PBM as "Specialty Drugs" must be filled through Lumicera Health Services specialty pharmacy or else that drug purchase will not be eligible for coverage under the Plan.	20% of the purchase price/Formulary prescription drug
Drugs Purchased After the 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. Generic drugs will be dispensed unless a generic equivalent is not available. If an available generic equivalent is refused, even if the prescribing physician has requested "Dispense as Written" (DAW), the covered person will be required to pay the brand 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-payment shown above after the in-network deductible is satisfied. A physician's prescription for these products is required. 3. Prescription drugs for the treatment of infertility are eligible for coverage under the Plan, 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, lifetime.	

Benefit Description	High Deductible Health Plan Prescription Drug Benefit Description
Prescription Drugs, cont. 4. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications, including, but not limited to, certain FDA-approved contraceptive agents and smoking cessation products with a prescription, as well as breast cancer medications that lower the risk of cancer or slow its development, without any cost-sharing provisions such as deductibles or co-payments. For more information about eligible preventive care medications, the covered person can contact the Pharmacy Benefits Manager (PBM) using the information listed on the front of his/her identification card. 5. As used in this benefit, the term "specialty prescription drug" means a drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty prescription drugs may be injectable medications, high-cost medications, or have special delivery and storage requirements (e.g., they may require refrigeration). Specialty prescription drug purchases will be limited to a 30-day supply, and prescriptions for such drugs must generally be filled through Lumicera Health Services specialty pharmacy or the drug will not be eligible for coverage under the Plan. For additional information about specialty prescription drugs, including information about which drugs are currently on the PBM's specialty prescription drug list, the Covered Person can contact the PBM using the information listed on the front of his/her identification card. 6. Unless specifically noted otherwise, prescription drugs that are not on the formulary drug list maintained by the PBM are not eligible for coverage under the Plan. If a covered person is using an excluded medication under the PBM's formulary list, he or she should speak to a physician to determine if there is an alternative therapy that provides the same therapeutic efficacy. Covered persons can contact the PBM using the phone number on the front of their identification cards for additional information about the coverage status of a particular drug.	

Coverage for dental and vision benefits comes as a combined package. Covered persons cannot elect coverage for one benefit type without the other. Once elected, dental and vision coverage must be elected for a two-year period.

Benefit Description	Dental Plan
	Limits
Benefit Year	July 1 through June 30
Benefit Percentage Type I - Preventive Dental Services Type II - Minor Restorative Dental Services Type III - Major Restorative Dental Services Type IV - Orthodontic Services (for Dependent children under age 24 only)	 100% 75% 75% 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 Eyeglass Lenses, Including Eyeglass Lens Add-Ons Such As Tinting, Ultraviolet Coatings, Scratch-Resistant Coatings, and Anti-Reflective Coatings Contact Lenses	 100% 100% 100%
Maximum Benefit Paid per Covered Person per Benefit Year for All Eligible Other Vision Services	$250