2017/2018 Benefits Guide
for Andrews University

Andrews University

Seek Knowledge. Affirm Faith. Change the World.

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The 2017 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 2017-2018 Andrews University Benefits Guide. Andrews University employees are its most valuable resource. As such, our employees should know that they are appreciated. 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 an important addition to each employee's life both on and off campus. These benefits make a meaningful 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 / Standard / High Deductible

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

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.			

Effective July 1, 2017

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Premier / Standard / High Deductible

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

ASR health benefits

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**
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%.	
Outpatient Physician Services (Includes Office Visits, Immediate Care Center Visits, Telemedicine E-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; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.

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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
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 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	$250 co-payment* per visit, then 100% (deductible waived) *may waive if admitted	Paid as in-network	80% after deductible	Paid as in-network
All Other Charges Billed by the Hospital, Physician, or Any Other Provider in Connection with the Emergency Room Visit	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.	Paid as in-network	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.	Paid as in-network	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.	Paid as in-network
Ambulance Transportation	90% after deductible	Paid as in-network	80% after deductible	Paid as in-network	80% after deductible	Paid as in-network

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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
Outpatient Services Surgery and Surgery-Related Services Chemotherapy and Radiation Therapy Hemodialysis Durable Medical Equipment Prosthetics and Orthotics Diagnostic X-Ray and Lab Test Services Pre-Admission Testing	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Allergy Services Injections, Serum, and Testing	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible

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Premier / Standard / High Deductible

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

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
Chiropractic Care						
Spinal Manipulations, Therapy Treatments, and a Physician's Fee for an Initial or Periodic Evaluation	$20 co-payment per day, then 100% (deductible waived)	$20 co-payment per day, then 100% (deductible waived)	$30 co-payment per day, then 100% (deductible waived)	$30 co-payment per day, then 100% (deductible waived)	80% after deductible	Paid as in-network
Diagnostic Spinal X-Rays	90% after deductible	Paid as in-network	80% after deductible	Paid as in-network	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)						
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
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	60% after deductible
Hearing Testing	90% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	Not covered
Hearing Aids	75% after deductible	Paid as in-network	75% after deductible	Paid as in-network	75% after deductible	Paid as in-network
$3,200 Lifetime Maximum Paid per Covered Person for All Eligible Hearing Aid Charges (In-Network and Out-of-Network Services Combined)						
Special Note about Hearing Services Benefit: Hearing screening tests of a newborn are covered under the Routine Preventive Care benefit.						

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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
Behavioral Care (Includes Mental Health Care and Addictions Treatment) Inpatient/Partial Hospitalization Services Outpatient/Intensive Outpatient Services, including Telemedicine E-Visits	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered.	
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.						
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

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ASR health benefits

Premier / Standard / High Deductible

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ASR health benefits

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 health benefits. If you fail to maintain your motor vehicle insurance, you will not have any health 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.

Coordination with Other Coverage for Injuries Arising out of Motorcycle Accidents
The following special coordination rule applies regarding motorcycle accidents. If a covered person is injured in an accident that involves a motor vehicle, claims will be processed in accordance with the Plan's position on motor vehicle accidents.

IF A COVERED PERSON IS OPERATING A MOTORCYCLE AND IS INJURED IN AN ACCIDENT THAT DOES NOT INVOLVE A MOTOR VEHICLE, THIS PLAN WILL EXCLUDE COVERAGE FOR THE FIRST $20,000 IN ELIGIBLE CHARGES OR, IF GREATER, THE AMOUNT OF HEALTH BENEFITS PAYABLE BY THE MOTORCYCLE INSURANCE POLICY. It is the responsibility of any covered person who operates a motorcycle to ensure that he or she is covered under a motorcycle insurance policy that will pay at least $20,000 in health benefits for him or her per accident. This requirement applies even if the covered person is not legally required to have such health benefit coverage. If the covered person fails to maintain $20,000 of coverage through a motorcycle insurance policy, the difference between the policy's maximum payout per accident (if any) and $20,000 will be the covered person's responsibility.

A covered person who is riding a motorcycle as a passenger and is injured in an accident that does not involve a motor vehicle will not be subject to this provision and will not have his or her otherwise eligible claims excluded from Plan coverage as described above.

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.

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ASR health benefits

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.

Health Savings Account (HSA)

Individuals enrolled in the High Deductible Health Plan option may be eligible to establish and maintain a health savings account (HSA). The terms of the HSA are governed by Section 223 of the Internal Revenue Code and the terms of the trust or custodial agreement establishing the HSA. Funds contributed to an HSA are not subject to federal income tax at the time of deposit and can be rolled over and accumulated from year to year if not spent. HSA funds can be used to purchase qualified medical expenses, for example, the cost of a doctor's office visit or a prescription drug. In 2017, you may contribute up to **$3,400** for single coverage or **$6,750** for family coverage to an HSA. Additional catch-up contributions (**$1,000**) may be made if you are age 55 or older.

An individual who contributes to a HSA should not participate in a non-HDHP for the entire plan year in which the contributions are made in order to be eligible for the HSA.

Important Information about Eligible Network Pharmacies

Prescriptions for covered prescription drugs must be filled at an eligible network pharmacy or else the drug will not be eligible for coverage under the Plan. To find an eligible network pharmacy, the covered person can contact the PBM using the information listed on the front of his/her identification card. It is recommended that covered persons confirm their preferred retail pharmacy is still in the network before filling a prescription. The following pharmacies will no longer be considered eligible network pharmacies for prescriptions filled on or after July 1, 2017:

Prescription drugs purchased from a pharmacy listed below will not be eligible for coverage under the Plan:

- CVS
- Walmart Pharmacy
- Arete Pharmacy Network
- Kroger Pharmacy
- Winn Dixie Pharmacy
- Third Party Station
- Publix Pharmacy
- TriNet Pharmacy
- American Pharmacy Network Solution
- Kmart Pharmacy
- H E B Pharmacy
- Hy-Vee Pharmacy
- Giant Eagle Pharmacy
- Shoprite Pharmacy
- SuperValu Pharmacy
- Delhaize Pharmacy
- Harris Teeter Pharmacy
- Brookshire Grocery Pharmacy

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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)	$150/Specialty drugs Prescriptions for specialty prescription drugs must be filled through Lumicera Health Services specialty pharmacy or the drug will not be eligible for coverage under the Plan.
Prescription Drug Maximum Out-of-Pocket per Benefit Year	$2,800/person* / $5,600/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. 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.

8. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan at 100% (no co-payment will be applied). The covered persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.

9. All prescriptions for covered prescription drugs must be purchased at an eligible network pharmacy or else the drug will **not** be covered under the Plan. To find an eligible network pharmacy, the covered person can contact the PBM using the information listed on the front of his/her identification card.

Effective July 1, 2017

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Premier / Standard / High Deductible

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

ASR health benefits

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
Specialty Prescription Drug Co-payment (30-Day Supply)	$200/Specialty drugs Prescriptions for specialty prescription drugs must be filled through Lumicera Health Services specialty pharmacy or the drug will not be eligible for coverage under the Plan.
Prescription Drug Maximum Out-of-Pocket per Benefit Year	$1,800/person* / $3,600/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. 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.

8. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan at 100% (no co-payment will be applied). The covered persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.

9. All prescriptions for covered prescription drugs must be purchased at an eligible network pharmacy or else the drug will **not** be covered under the Plan. To find an eligible network pharmacy, the covered person can contact the PBM using the information listed on the front of his/her identification card.

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Premier / Standard / High Deductible

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

ASR health benefits

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 in-network deductible. If an eligible prescription drug is purchased at a pharmacy within the appropriate network, through the Mail Service Program, or from the Lumicera Health Services specialty pharmacy, 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)	20% of the purchase price/Formulary prescription drug Prescriptions for specialty prescription drugs must be filled through Lumicera Health Services specialty pharmacy or the drug will not be eligible for coverage under the Plan.
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. 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.

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. 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.

7. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan at 100% (no co-payment or deductible will be applied). The covered persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.

8. All prescriptions for covered prescription drugs must be purchased at an eligible network pharmacy or else the drug will **not** be covered under the Plan. To find an eligible network pharmacy, the covered person can contact the PBM using the information listed on the front of his/her identification card.

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Dental and Vision Plan

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

ASR health benefits

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
Deductible per Benefit Year	$25 / person $75 / family
Benefit Percentage	
Type I - Preventive Dental Services	100%; deductible waived (0% coinsurance)
Type II - Minor Restorative Dental Services	75% after deductible (25% coinsurance)
Type III - Major Restorative Dental Services	75% after deductible (25% coinsurance)
Type IV - Orthodontic Services (for dependent children under age 24 only)	50% after deductible (50% coinsurance)
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.	$1,100
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% (0% coinsurance) *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% (0% coinsurance)
Eyeglass Lenses, Including Eyeglass Lens Add-Ons Such As Tinting, Ultraviolet Coatings, Scratch-Resistant Coatings, and Anti-Reflective Coatings	100% (0% coinsurance)
Contact Lenses	100% (0% coinsurance)
Maximum Benefit Paid per Covered Person per Benefit Year for All Eligible Other Vision Services	$250

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FSA / Limited Purpose FSA

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

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. An FSA is an employer-established benefit plan that is 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) sets a maximum amount of money that you can contribute to an FSA, and your employer may set a minimum contribution. 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

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). An employer may set the annual maximum contribution no higher than $2,600, per federal law. You may submit claims for yourself and your eligible dependents, including your spouse, children, and any other person who is a qualified IRS dependent.

The medical FSA operates much like a bank account. Deposits are made into the account in the form of pretax payroll deductions. 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. 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.

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 lodging
- Uniforms
- Vitamins taken for general health purposes

ASR health benefits

Alternatively, your employer offers a more convenient method of reimbursement, a Benefits (debit) Card. You can manage your account at www.asrhealthbenefits.com.

Review your past medical expenses and plan your future needs carefully to decide if the medical FSA is right for you. Also, note the deductible, coinsurance, and co-payment amounts required in the health plan option that you have selected, as they can also be reimbursed from your medical FSA. For a complete list of eligible and ineligible medical expenses, refer to Internal Revenue Publication 502 at www.irs.gov.

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 and routine tests), 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 your participation is 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.

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. Alternatively, your employer offers a more convenient method of reimbursement, a Benefits (debit) Card. You can manage your account at www.asrhealthbenefits.com.

Dependent care expenses are expenses you incur 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. Please refer to Internal Revenue Publication 503 for more information on eligible and ineligible expenses at www.irs.gov.

FSA / Limited Purpose FSA

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

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 FSA at the time and place the expense is incurred. 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.

By law, merchants may choose to require either a signature debit or a personal identification number (PIN) debit. If you do not have a PIN or forget your PIN, the merchant can run the transaction as a signature debit or require another form of payment. You may obtain your PIN by calling (866) 898-9795. Your PIN is system generated and cannot be customized. If your card is lost or stolen or if you lose or forget your PIN, you can reset your PIN by calling the tollfree number above. You are unable to make cash withdrawals at ATMs or at stores that allow for cash back on PIN debit purchases.

When you use your ASR Health 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 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 the FSA-eligible items that you purchase with your ASR Health Benefits Card.

Make sure that you use your ASR Health Benefits Card only for FSA-eligible expenses! If you purchase an ineligible item using your ASR Health 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 your ASR Health Benefits Card, 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 ASR Health Benefits Card at merchants that have an IIAS in place or you may purchase them manually, without a prescription.

GRACE PERIOD

Your medical 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 have a time period after that in which to submit (but not incur) the claims. You must forfeit any funds remaining in your FSA at the end of the grace period.

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 2018, you have $250 left in your medical FSA. You incur $250 of qualified medical expenses during July 1 through September 15 of 2018, the grace period for the 2017-18 plan year. You may submit these expenses before December 15, 2018 in order to receive reimbursement.

ASR health benefits

All employees that are enrolled in the High Deductible Health Plan are eligible to open a Health Savings Account (HSA).

You determine what portion of your paycheck you would like to be deducted (if any) on a tax-free basis and placed into an account that you open at a financial institution of your choice. You will need to complete the HSA Response Form upon opening your HSA and return it to HR.

2017 Annual Contribution Maximums

Single: $3,400 Family: $6,750

Funds can be used for eligible out-of-pocket medical, dental, vision, and hearing expenses and unlike the FSA, unused monies will rollover from year to year and can earn interest, also tax-free.

Eligible Expenses Include (but are not limited to):
Ambulance Fees
Medical/Dental Deductibles
Coinsurance
Copays
Lab Fees
Prescription Drugs
Durable Medical Equipment
Diabetic Supplies
Bandages
Glasses/Frames/Contacts

Ineligible Expenses Include (but are not limited to):
Cosmetic Surgery
Nonprescription Drugs
Personal Use Items
Insurance Premiums (while actively employed)
Teeth Whitening
Nonprescription Glasses

You cannot use HSA funds for items that have been paid for or have been reimbursed by a Flexible Spending Account (no double dipping). For additional information, consult your tax advisor and/or visit www.treas.gov.

Andrews University has determined that the prescription drug coverage offered by the Qualified High Deductible Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. **Therefore, your coverage is considered Non-Creditable Coverage.** This might result in a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

2017/18 Andrews University Health & Wellness Management Program
Live Wholly

PREMIUM DISCOUNT
To receive the full wellness discount on health premiums effective July 1, 2017, all employees (including health-eligible secondary spouse employees) must complete the following two requirements:

1. Complete the brief wellness survey on the FitThumb e-wellness platform in February

AND

2. Attend a town hall meeting in March

FEBRUARY
The FitThumb survey will be available for completion in the month of February.

MARCH
Attend one of the following town hall sessions (two similar sessions each day)
- March 2
- March 8
- March 13
- March 21

APRIL
As the discount requirements will have been completed by the end of March, you will be able to confirm your discounted premium in the bswift system when you go through the online open enrollment process.

Life / AD&D (Unum Flex Life)

Base Life: Unum – 35 Hours – AF/SA/SF/FA/FF/FT/HF
AD&D and Voluntary Supplemental Life: Unum – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP/HF/HP/HH

Better benefits at work.

Standard Features	
Eligibility	**All eligible employees in active employment in the United States with the Employer.**
Who pays for the cost of coverage?	**Your Basic Benefit** • Your employer pays the cost of your coverage **Your Additional Benefit** • You pay the cost of your coverage **Base Coverage for your Dependents** • Your employer pays the cost of coverage for your spouse and children **Additional Coverage for your Dependents** • You pay the cost of coverage for your spouse and children
Base Life coverage for You	**Base Life Benefit Amount** • $100,000 **Non-Medical Maximum** • $100,000 All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.
Additional Life and Accidental Death & Dismemberment coverage for You	**Additional Life Benefit Options** • 7x annual earnings, rounded to the next higher multiple of $10,000, if not already an exact multiple thereof; or $750,000 **Additional AD&D Benefit Options** • 7x annual earnings, rounded to the next higher multiple of $10,000, if not already an exact multiple thereof; or $750,000 **Non-Medical Maximum** • The lesser of 3x annual earnings or $250,000 All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.
Base Life coverage for your dependents	**Base Spouse Life Benefit Options** • $50,000 **Non-Medical Maximum** • $50,000 **Base Child Benefit Options** Live birth but under the age 19 years • $10,000 **Dependent Child Age Limit(s)** • 19 years • 25 if a full-time student **The amount of Life Insurance for a dependent will not be more than 100% of your life amount. You must be covered for Life in order to insure dependents for Life.*

Life / AD&D (Unum Flex Life)

Base Life: Unum – 35 Hours – AF/SA/SF/FA/FF/FT/HF
AD&D and Voluntary Supplemental Life: Unum – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP/HF/HP/HH

Better benefits at work.

Standard Features	
Additional Life & Accidental Death & Dismemberment coverage for your dependents	**Additional Spouse Life Benefit Options** • Amounts in $5,000 benefit units to an overall maximum of $250,000 as applied for by you and approved by Unum **Non-Medical Maximum** • $50,000 **Additional Spouse AD&D Benefit Options** • Amounts in $5,000 benefit units to an overall maximum of $250,000 as applied for by you and approved by Unum **Additional Child Life Benefit Options** Live birth but under the age 19 years • Amounts in $5,000 benefit units to an overall maximum of $25,000 as applied for by you and approved by Unum **Additional Child AD&D Benefit Options** Live birth but under the age 19 years • Amounts in $5,000 benefit units to an overall maximum of $25,000 as applied for by you and approved by Unum **Dependent Child Age Limit(s)** • 19 years • 25 if a full-time student **The amount of Life Insurance for a dependent will not be more than 100% of your life amount. You must be covered for Life in order to insure dependents for Life.*
AD&D Covered Losses and Benefits	**Benefit Amount (For loss of):** **Full Benefit** • Life • Both hands, or both feet, or sight of both eyes • One hand & one foot • One hand or foot & sight of one eye • Speech and hearing **Half Benefit** • One hand or one foot • Sight of one eye • Speech or hearing **Quarter Benefit** • Thumb and index finger of the same hand
AD&D Education Benefit	An additional lump sum benefit, to each qualified child (provided death occurs within 365 days of the accidental bodily injury), equal to the lessor of: • 6% of the employee's AD&D benefit amount, or • $6,000 Maximum benefit payment 4 per lifetime. Maximum benefit amount $24,000. Maximum benefit period 6 years from the date of the first benefit payment.
AD&D Repatriation Benefit	Unum will pay an additional AD&D benefit of up to $5,000 for the preparation and transportation of your remains if the death occurs at least 100 miles from your principal residence.

Life / AD&D (Unum Flex Life)

Base Life: Unum – 35 Hours – AF/SA/SF/FA/FF/FT/HF
AD&D and Voluntary Supplemental Life: Unum – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP/HF/HP/HH

Better benefits at work.

Standard Features	
AD&D Seatbelt and Airbag Benefit	Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which results in death while properly wearing a seatbelt and protected by an airbag. **Benefit Amount:** • Seatbelt: 10% of the full amount of your AD&D benefit • Airbag: 5% of the full amount of your AD&D benefit **Maximum Benefit:** • Seatbelt: $25,000 • Airbag: $5,000
Portability	If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may be eligible to elect portable coverage and continue your term insurance at group rates.
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.
Exclusions & Limitations	
Coverage Exclusions – Life Insurance	Life benefits will not be paid when death is caused by, contributed to by, or results from suicide that occurs within 24 months after the initial effective date of the insurance and/or occurs within 24 months after the date any increase or additional insurance becomes effective.
Coverage Exclusions – AD&D Insurance	AD&D benefits are excluded (not paid) for losses caused by, contributed to by, or resulting from: • self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane; • active participation in a riot; • an attempt to commit or commission of a crime; • the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your or your dependent's physician. This exclusion will not apply to you or your dependent if the chemical substance is ethanol; • disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders; • being intoxicated; • war, declared or undeclared, or any act of war.
Enrollment	
Questions	If you should have any questions about your coverage or how to enroll, please contact your Plan Administrator.
Changes to Coverage	At each annual enrollment period or within 31 days of a change in status, you will be given the opportunity to change your coverage.
Delayed Effective Date of Coverage	**Employee:** Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. **Dependent:** Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth. "Totally disabled" means that, as a result of an injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Some provisions may vary or not be available in all states. Please refer to your certificate booklet for a complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Underwritten by: **Unum Life Insurance Company of America 2211 Congress Street, Portland, Maine 04122, www.unum.com**

Long Term Disability

Unum – 35 Hours – AF/SA/SF/FA/FF/FT/HF

Better benefits at work.

Standard Features	
Eligibility	**All eligible Full-Time Employees in active employment in the United States with the Employer.**
Monthly Benefit Amount	The monthly benefit will be the lesser of: • **66.67%** of monthly earnings; or • a maximum monthly benefit of **$6,000** Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.
Minimum Monthly Benefit	An amount equal to the **greater** of: • $100; or • 10% of your gross disability payment.
Elimination Period	You must be continuously disabled through your elimination period. The days that you are not disabled will not count toward your elimination period. **Your elimination period is 90 days.** In addition, if you return to work while satisfying your elimination period, and are no longer disabled, you may satisfy your elimination period within the accumulation period. You do not need to be continuously disabled through your elimination period if you are satisfying your elimination period under this provision. If you do not satisfy the elimination period within the accumulation period, a new period of disability will begin. **Your accumulation period is 180 days.** You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.
Duration of Benefit	Your duration of benefits is based on your age when the disability occurs. Your LTD benefits are payable for the period during which you continue to meet the definition of disability and in accordance with the **SS ADEA (Social Security Normal Retirement Age)** duration schedule.
Definition of Disability	**2 Year Own Occupation with Residual** You are disabled when Unum determines that: • you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and • you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury. After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience. You must be under the regular care of a physician in order to be considered disabled.
Survivor Benefit	When Unum receives proof that you have died, we will pay your eligible survivor a lump sum benefit equal to **3 months of your gross disability payment** if, on the date of your death: • your disability had continued for 180 or more consecutive days; and • you were receiving or were entitled to receive payments under the plan.
Rehabilitation and Return to Work Services	The rehabilitation program may include, but is not limited to, the following services and benefits: • coordination with your Employer to assist you to return to work; • adaptive equipment or job accommodations to allow you to work; • vocational evaluation to determine how your disability may impact your employment options; • job placement services; • resume preparation; • job seeking skills training; or • education and retraining expenses for a new occupation.
Rehabilitation and Return to Work Benefits	We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month. This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while: • you are participating in the Rehabilitation and Return to Work Assistance program; and • you are not able to find employment.

Long Term Disability

Unum – 35 Hours – AF/SA/SF/FA/FF/FT/HF

Better benefits at work.

Exclusions & Limitations	
Pre-existing Condition	You have a pre-existing condition if: • you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the **3 months** just prior to your effective date of coverage; • the disability begins in the first **12** months after your effective date of coverage unless you have been **treatment free** for **3** consecutive months after your effective date of coverage
Mental Nervous and Self Reported Symptoms Limitation	The lifetime cumulative maximum benefit period for all disabilities due to mental illness and self Reported symptoms is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities: • are not continuous; and/or • are not related. Payments would continue beyond 24 months if you are confined to a hospital or institution as a result of the disability.
Coverage Exclusions	Your plan does not cover any disabilities caused by, contributed to by, or resulting from your: • intentionally self-inflicted injuries; • active participation in a riot; • loss of a professional license, occupational license or certification; • commission of a crime for which you have been convicted; • pre-existing condition. Your plan will not cover a disability due to war, declared or undeclared, or any act of war. Unum will not pay a benefit for any period of disability during which you are incarcerated.

See Human Resources for further detailed information on the Long Term Disability Plan.

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Please refer to your certificate booklet for a complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Underwritten by: **Unum Life Insurance Company of America 2211 Congress Street, Portland, Maine 04122, www.unum.com**

Travel Assistance

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

Don't forget this travel essential!

Pack your worldwide emergency travel assistance phone number and leave travel worries at home

Better benefits at work.

If you experienced a medical emergency while traveling, would you know who to call?

Whenever you travel 100 miles or more from home — to another country or just another city — be sure to pack your worldwide emergency travel assistance phone number! Travel assistance speaks your language, helping you locate hospitals, embassies and other "unexpected" travel destinations. Add the number to your cell phone contacts, so it's always close at hand! Just one phone call connects you and your family to medical and other important services 24 hours a day.

Use your travel assistance phone number to access:

- Hospital admission assistance*
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

24/7 services anywhere in the world

Unum's travel assistance services are provided by Assist America, Inc., a leading provider of global emergency assistance services through employee benefit plans. Assist America's medically certified personnel are ready to help 24 hours a day, 365 days a year, and can connect you with pre-qualified, English-speaking and Western-trained medical providers anywhere in the world.

You can access travel assistance services through the **phone number on your travel assistance wallet card**. If you have misplaced your card, contact your human resources department and ask for a replacement.

Whether traveling for business or pleasure, one phone call connects you to:

- Multi-lingual, medically certified crisis management professionals
- A state-of-the-art global response operations center
- Qualified medical providers around the world

Travel assistance FAQs

Q. Which countries can I travel to?

A. Assist America's services have no geographical exclusions. Its worldwide network stands ready to help wherever your travels take you.

Q. Is my family covered?

A. Your spouse and dependent children up to age 19 (or the age specified by your medical plan) are covered. Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

Q. Are pre-existing conditions excluded?

A. No. Whether your medical emergency is the result of a new or pre-existing condition, Assist America's trained representatives will help you find qualified medical care and facilities.

Q. What about sports-related injuries?

A. Whether you've been involved in recreational or extreme sporting, worldwide emergency travel assistance will provide support for all your medical needs.

Q. Who pays for the services I use if I have a travel emergency?

A. Assist America arranges and pays for 100% of the services the company provides, with no caps or charge-backs to either you or your employer. But you must call Assist America first — you can't be reimbursed for services you arrange on your own.

* Hospital admission is coordinated by Assist America, Inc. It may require a validation of your medical insurance or an advance of funds to the foreign medical facility. You must repay any expenses related to emergency hospital admissions to Assist America, Inc. within 45 days.

Worldwide emergency travel assistance services are provided by Assist America Inc. All emergency travel assistance must be arranged by Assist America, which pays for all services it provides. Medical expenses such as prescriptions or physician, lab or medical facility fees, are paid by the employee or the employee's health insurance. Services are available with selected Unum insurance offerings. Exclusions, limitations and prior notice requirements may apply, and service features, terms and eligibility criteria are subject to change. These services are not valid after termination of coverage and may be withdrawn at any time. Employees are covered for business or personal travel; spouses and dependent children are covered for personal travel only. Please contact your Unum representative for full details. For trips longer than 90 days, expatriate coverage is available. Call the number provided for more information.

Insurance products underwritten by the subsidiaries of Unum Group.

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Employee Assistance Program (EAP)

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

Better benefits at work.

Life's stresses aren't a game

Real solutions are close at hand with the Employee Assistance Program (EAP)

When you have questions, concerns or emotional issues surrounding your personal or work life, you can count on us to offer help. Unum's work-life balance employee assistance program (EAP) offers unlimited access to master's-level consultants by telephone, resources and tools online, and up to three face-to-face visits with a consultant for help with a short-term problem.*

Help for personal challenges, big and small

Keeping your work and personal life in balance can sometimes be tricky. Stressful situations can affect your health, well-being and ability to focus on what's important.

That's when you can pick up the phone and speak confidentially** to a master's-level consultant who can help you or a family member to:

- **Locate child care and elder care services** and obtain matches to the appropriate provider based on your or your family's preferences and criteria. The consultant will even confirm space availability.
- **Speak with financial experts** by phone regarding issues such as budgeting, controlling debt, teaching children to manage money, investing for college, and preparing for retirement
- **Work through complex, sensitive issues** such as personal or work relationships, depression or grief, or issues surrounding substance abuse
- **Get a referral to a local attorney** for a free, 30-minute in-person or telephonic legal consultation

You'll have access to an attorney for state-specific legal information and services. If you decide to retain the attorney, you may be eligible to receive a 25% discount on additional services.

You also have unlimited website access at lifebalance.net where you can:

- Read booklets, life articles and guides
- View videos and online seminars, as well as listen to podcasts
- Subscribe to email newsletters
- Find information on parenting, retirement, finances, education and more
- Use health management online calculators and other tools to help you with topics such as losing weight or starting a new exercise program
- Access links to other informative websites
- Use school, camp, elder care and child care locators
- Use financial calculators, retirement planners, worksheets and more

Help with stress
A satisfaction survey of employees who used work-life balance EAP shows nearly 75% reported less stress.[1]

Guidance for work-related conflicts

If you're a manager dealing with staff issues such as an employee who's feeling overwhelmed by his or her workload, you have unlimited access to guidance from a team of consultation experts. Call the toll-free work-life balance EAP number to:

- Have a confidential sounding board and objective view
- Work on communication and problem-solving skills
- Learn how to motivate your employees

If you are a supervisor or working to become one, you can visit the website at lifebalance.net to get information on managing people using resources such as:

- Electronic management newsletters
- Podcasts and articles for managers
- Self-assessment tools to be a better manager

If you would like to listen to podcasts and audio tracks on the go — or read articles or digital booklets on a mobile device—download the LifeWorks mobile app from your app store on your mobile device.

In addition to the LifeWorks app, a wallet card that includes the work-life balance EAP phone number and online access information is available. Please see your human resources department to request one.

Balance can be a call or click away:
1-800-854-1446, English
1-877-858-2147, Spanish
1-800-999-3004, TTY/TDD
www.lifebalance.net (user ID and password: lifebalance)

* In California and Nevada, employees and their family members may confer with a local consultant up to three times in a six-month time period.

** The consultants must abide by federal regulations regarding duty to warn of harm to self or others. In these instances the consultant may be mandated to report a situation to the appropriate authority.

[1] Ceridian, *2012 4th Quarter Performance Dashboard Survey, Unum Group LTD and Life* (December 2012).

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The Work-life Balance EmployeeAssistance Program, provided by Ceridian HCM, is available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Insurance products are underwritten by the subsidiaries of Unum Group.

Voluntary Short Term Disability

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

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

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

Better benefits at work.

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

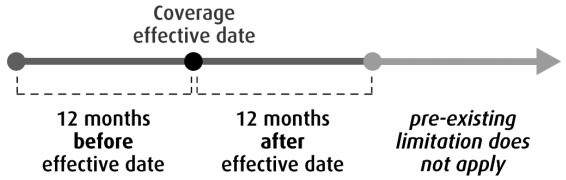
1. You own the policy so you can keep it even if you leave the company or retire. Unum will bill you directly for the same premium amount.
2. Coverage becomes effective on the first day of the month in which payroll deductions begin.
3. Your policy is guaranteed renewable, until age 72, as long as you 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/HF/HP/HH

Better benefits at work.

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/HF/HP/HH

Better benefits at work.

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/HF/HP/HH

Better benefits at work.

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/HF/HP/HH

Better benefits at work.

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 – 20 Hours – AF/AP/SA/SF/SP/FA/FF/FT/FP/HF/HP/HH

Better benefits at work.

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

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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.

When traveling outside of the United States, the plan will provide coverage for medically necessary services, drugs, and supplies should you require urgent or emergency care; however, most foreign providers will require that you pay for such services in full at the time of treatment. You must then submit a receipt (translated into English if possible) to ASR or Navitus in order to receive reimbursement for the expense. Charges are subject to the in-network level of benefits if you contact ASR and explain that you received urgent or emergency care while traveling, and that you could not reasonably be expected to know the location of the nearest in-network provider (if any). Otherwise charges will be subject to the out-of-network level of benefits. Please note that the plan will not cover charges incurred outside of the United States if the primary purpose of the travel is to obtain medical services, drugs, or supplies (except as covered under the Global Healthcare Benefit). Additionally, the plan will not cover services, procedures, or treatment in a foreign country that are not normally covered under the terms of the plan.

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**.

Defined Contribution Retirement Plan

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 Empower Retirement 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.empower-retirement.com/participant, providing secure 24-hour Internet access to your account and investment information.
2. Key Talk toll free at 866-467-7756, a phone automated information service providing you with the same easy-to-use account services as the Web site.

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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 Empower 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 Empower Retirement Education Counselor in this area is Kim Talton, whose contact information follows:

Kim Talton
Email: kim.talton@empower-retirement.com
Work/Cell Phone: 312-965-7032
www.empower-retirement.com

To activate or change your contribution rate, you may do so by logging in with your Andrews University username and password on the online benefit management system at www.andrews.edu/go/mybenefits.

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.) Dependent children enrolled in the Adventist Colleges Abroad are eligible for tuition assistance benefit. Employees eligible for dependent tuition assistance whose spouse is denominationally employed and also eligible for tuition benefits will receive half of the computed benefits.

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.
- For all employees, 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 for 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 for a maximum of ten semesters of undergraduate or graduate study; graduate study must occur at Andrews University in order to be eligible. The number of semesters eligible for assistance is prorated, based on prior university enrollment, when eligibility begins. Enrollment in summer semesters count against the ten semester total.

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.

The payment of the scholarship will be made directly to the school involved.

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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 through the doctoral level. 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, or FT) 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.

The Internal Revenue Service (IRS) considers employer-provided graduate tuition assistance as part of your wage package therefore the assistance may be subject to tax withholding. Per IRS code section 127, tuition assistance for employees at the graduate-level are tax free for the first $5,250 per calendar year. All graduate level tuition assistance for employees' spouses must be included as taxable income of the employee, as required by the IRS.

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—please see full policy online.

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 and personal time (10, 15, or 20 days), holidays (9 days—see below), and short-term sick leave (6 days).

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)

Notes

Notes

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
Medical/Vision/Dental Plan PhysiciansCare (ASR Health Benefits) Medical/dental/vision claims, coverage, find a physican	T: 800.968.2449 F: 616.464.4458 www.asrhealthbenefits.com
Flexible Spending Accounts PhysiciansCare (ASR Health Benefits)	T: 800.968.2449 F: 616.464.4458 www.asrhealthbenefits.com
Live Wholly	Dominique Wakefield T: 269.471.6165 www.andrews.edu/wellness wellness@andrews.edu #aulivewholly
Networks While Traveling CIGNA Network Multiplan	 www.cigna.com www.multiplan.com
Pharmaceutical Plan Navitus NoviXus	 T: 866.333.2757 www.navitus.com T: 877.668.4987
Retirement Empower Retirement	Kim Talton T: 312.965.7032 kim.talton@empower-retirement.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
Voluntary Accident Plan Unum	 T: 800.635.5597
Supplemental Life Insurance / **Accidental Death & Dismemberment** Unum *(Contact AU Benefits Office)*	 T: 800.421.0344
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
Employee Travel Assistance Program	T: 800.872.1414
Employee Assistance Program (EAP)	T: 800.854.1446

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. 2017-2018.