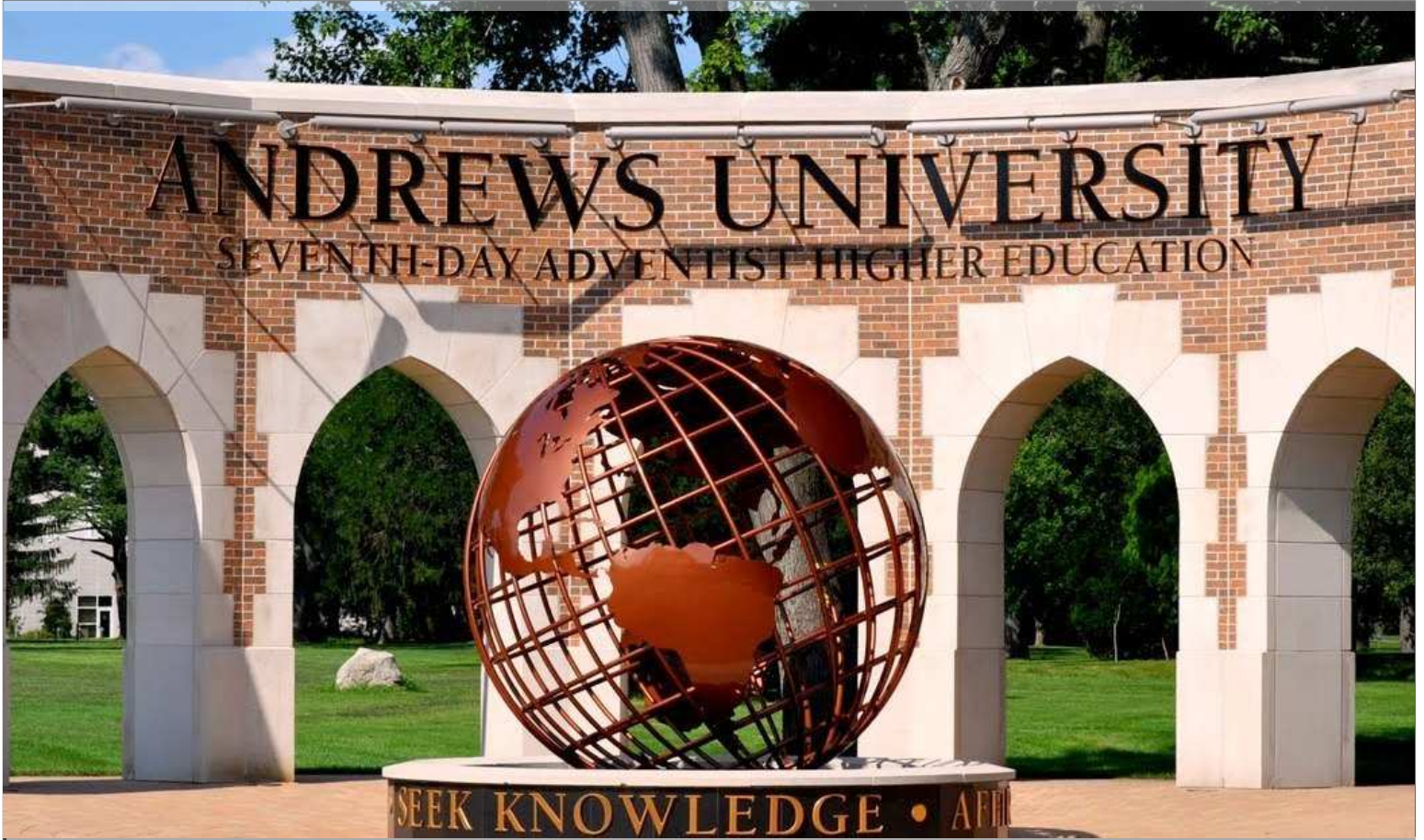


Andrews University 2019/2020 Benefits Guide



Andrews  University

Seek Knowledge. Affirm Faith. Change the World.

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Welcome to the 2019-2020 Andrews University Benefits Guide.

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

This guide will walk you through your benefits, to help 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 a better understanding of your benefits will produce a team more committed to our mission of serving Christ and also our passion of educating young people to commit their lives to changing the world. Please keep this guide as a reference tool to use through the year as questions arise regarding any of your benefits.

The 2019-2020 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.

The following benefits are available to employees working the following hours:

- **Medical:** 30 hours
- **Dental and Vision:** 30 hours
- **FSA / Limited Purpose FSA:** 30 hours
- **HSA:** 30 hours
- **Employer paid Life:** 35 hours
- **Supplemental Life/AD&D:** 20 hours
- **Long Term Disability:** 35 hours
- **Travel Assistance:** 20 hours
- **Employee Assistance Program:** 20 hours
- **Voluntary Short Term Disability:** 20 hours
- **Voluntary Accident Plan:** 20 hours
- **Voluntary Critical Illness:** 20 hours
- **Whole Life:** 20 hours
- **Time-Off, Tuition Assistance, Retirement, Free Class:** See Important Information section



Medical Plan Options—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
Benefit Year	July 1 through June 30		July 1 through June 30		July 1 through June 30	
Deductible per Benefit Year	\$500/person \$1,000/family	\$3,000/person \$6,000/family	\$650/person \$1,300/family	\$3,000/person \$6,000/family	\$1,450/single \$2,900/family	\$3,000/single \$6,000/family
	Special Note About the Benefit Year Deductible: An individual within a family has to meet only the per-person deductible specified above before the Plan will begin paying benefits. Only charges billed by in-network providers will accrue toward the deductible for in-network services, and only charges billed by out-of-network providers will accrue toward the deductible for out-of-network services.		Special Note About the Benefit Year Deductible: An individual within a family has to meet only the per-person deductible specified above before the Plan will begin paying benefits. Only charges billed by in-network providers will accrue toward the deductible for in-network services, and only charges billed by out-of-network providers will accrue toward the deductible for out-of-network services.		Special Note About the Benefit Year Deductible: The family deductible must be met in full, either by one covered family member or by any combination of covered family members, before the Plan will begin paying benefits for any individual. Only charges billed by in-network providers will accrue toward the deductible for in-network services, and only charges billed by out-of-network providers will accrue toward the deductible for out-of-network services.	
General Benefit Percentage	90% after deductible (10% coinsurance)	60% after deductible (40% coinsurance)	80% after deductible (20% coinsurance)	60% after deductible (40% coinsurance)	80% after deductible (20% coinsurance)	60% after deductible (40% coinsurance)
Coinsurance Maximum Out-of-Pocket per Benefit Year	\$2,850/person* \$5,700/family*	\$5,000/person* \$10,000/family*	\$3,700/person* \$7,400/family*	\$5,000/person* \$10,000/family*	Not applicable to this plan option; refer to the Total Maximum Out-of-Pocket stated below	
	*An individual within a family has to meet only the per-person Coinsurance Maximum Out-of-Pocket before the Plan's benefits will increase to 100%. Only charges billed by in-network providers will accrue toward the Coinsurance Maximum Out-of-Pocket for in-network services, and only charges billed by out-of-network providers will accrue toward the Coinsurance Maximum Out-of-Pocket for out-of-network services.		*An individual within a family has to meet only the per-person Coinsurance Maximum Out-of-Pocket before the Plan's benefits will increase to 100%. Only charges billed by in-network providers will accrue toward the Coinsurance Maximum Out-of-Pocket for in-network services, and only charges billed by out-of-network providers will accrue toward the Coinsurance Maximum Out-of-Pocket for out-of-network services.			
Total Maximum Out-of-Pocket per Benefit Year	\$4,350/person** \$8,700/family**	Not applicable	\$5,350/person** \$10,700/family**	Not applicable	\$3,250/single* \$6,500/family*	\$8,000/single* \$16,000/family*
	**Includes deductible, coinsurance, and medical co-payments. Does not include prescription drug co-payments or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. Only charges billed by in-network providers will accrue toward the Total Maximum Out-of-Pocket for in-network services. An individual within a family has to meet only the per-person Total Maximum Out-of-Pocket before the medical co-payments will no longer be charged for the remainder of the benefit year. Prescription drug co-payments track toward a separate Prescription Drug Maximum Out-of-Pocket to the extent required by Health Care Reform (see the separate Prescription Drug Benefit summary for more information).		**Includes deductible, coinsurance, and medical co-payments. Does not include prescription drug co-payments or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. Only charges billed by in-network providers will accrue toward the Total Maximum Out-of-Pocket for in-network services. An individual within a family has to meet only the per-person Total Maximum Out-of-Pocket before the medical co-payments will no longer be charged for the remainder of the benefit year. Prescription drug co-payments track toward a separate Prescription Drug Maximum Out-of-Pocket to the extent required by Health Care Reform (see the separate Prescription Drug Benefit summary for more information).		*Includes deductible, coinsurance, and co-payments (if applicable). Does not include expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. All co-payments, including prescription drug co-payments (if any), specified below will no longer apply once the Total Maximum Out-of-Pocket is satisfied in a Benefit Year. Only charges billed by in-network providers will accrue toward the Total Maximum Out-of-Pocket for in-network services, and only charges billed by out-of-network providers will accrue toward the Total Maximum Out-of-Pocket for out-of-network services. The family Total Maximum Out-of-Pocket must be met in full, either by one covered family member or by any combination of covered family members before the Plan's benefits will increase to 100%.	

Medical Plan Options—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
<p><u>Outpatient Physician Services (Includes Office Visits, Telemedicine E-Visits, and Second Surgical Opinions) Physician's Fee for an Examination</u></p> <p>All Other Charges Billed in Connection with the Examination</p>	<p>\$20 co-payment per visit, then 100% (deductible waived)</p> <p>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</p>	<p>60% after deductible</p> <p>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</p>	<p>\$30 co-payment per visit, then 100% (deductible waived)</p> <p>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</p>	<p>60% after deductible</p> <p>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</p>	<p>80% after deductible</p> <p>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</p>	<p>60% after deductible</p> <p>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</p>
<p><u>Routine Preventive Care</u></p> <p>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</p>	<p>100%; deductible waived</p>	<p>Not covered</p>	<p>100%; deductible waived</p>	<p>Not covered</p>	<p>100%; deductible waived</p>	<p>Not covered</p>
<p><u>Urgent Care Center Visits</u></p> <p>Physician's Fee for an Examination</p> <p>All Other Charges Billed in Connection with the Examination</p>	<p>\$75 co-payment per visit, then 100% (deductible waived)</p> <p>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</p>	<p>60% after deductible</p> <p>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</p>	<p>\$75 co-payment per visit, then 100% (deductible waived)</p> <p>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</p>	<p>60% after deductible</p> <p>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</p>	<p>80% after deductible</p> <p>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</p>	<p>60% after deductible</p> <p>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</p>
<p><u>Emergency Room Treatment</u></p> <p>Hospital's Fee for the Use of the Emergency Room</p>	<p>\$250 copayment* per visit, then 100% (deductible waived)</p> <p>*may waive if admitted</p>	<p>Paid as in-network</p>	<p>\$250 copayment* per visit, then 100% (deductible waived)</p> <p>*may waive if admitted</p>	<p>Paid as in-network</p>	<p>80% after deductible</p>	<p>Paid as in-network</p>

Medical Plan Options—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
<u>Emergency Room Treatment</u> , cont. All Other Charges Billed by the Hospital, Physician, or Any Other Provider in Connection with the ER 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
Authorization Requirement \$250 Penalty for Non-Compliance	Inpatient hospital confinements and observational stays Home and outpatient rehabilitative therapy Durable medical equipment if the purchase price or forecasted total rental cost is \$2,500 or more Home health care Custom-made orthotic or prosthetic appliances if the purchase price is \$2,500 or more Oncology treatment Infusion or injection of select products					
<u>Inpatient Hospital Services</u> 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
<u>Inpatient Physician Services</u> Hospital Visits, Surgical Procedures, and Anesthesiology	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
<u>Outpatient Services</u> Surgery and Surgery-Related Services Chemotherapy and Radiation Therapy Hemodialysis Durable Medical Equipment Prosthetics and Orthotics, Diagnostic X-Rays 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
<u>Allergy Services</u> Injections, Serum, and Testing	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Infusion/Injection Therapy	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Special Note about the Outpatient Infusion/Injection Therapy Benefit: Effective July 1, 2019, the infusion or injection of select products will be subject to the Plan's Certification Requirement (see above). The list of the select products can be accessed by logging on to www.asrhealthbenefits.com or by calling ASR Health Benefits at (800) 968-2449. Beginning September 1, 2019, the Plan will not cover the infusion or injection of select products at an outpatient hospital facility, which means the covered person will have to pay for the full cost of that care, unless the Plan determines that any of the following exceptions apply: (1) treatment is medically appropriate in a facility setting rather than a home, office, or free-standing infusion center setting; (2) the medication is subject to limited distribution and is available only at certain facilities; or (3) the covered person would have to travel more than 50 miles from his or her home to receive services in an office or free-standing infusion center setting, or the provider is a Plan-approved site of service. A covered person can call the telephone number on the front of his or her health plan identification card to confirm whether a provider is a Plan-approved site of service.						
<u>Chiropractic Care</u> 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

Medical Plan Options—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
<u>Chiropractic Care, cont.</u> Diagnostic Spinal X-Rays \$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)	90% after deductible	Paid as in-network	80% after deductible	Paid as in-network	80% after deductible	Paid as in-network
<u>Massage Therapy (Medically Necessary Services Only)</u> \$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
<u>Rehabilitative Therapy</u> 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
<u>Hearing Services</u> Hearing Exams Hearing Testing Hearing Aids \$2,500 Maximum Paid per Covered Person in Any Two-Benefit-Year-Period for All Eligible Hearing Aid Charges (In-Network and Out-of-Network Services Combined)	\$20 co-payment per visit, then 100% (deductible waived) 90% after deductible 75% after deductible	Not covered Not covered Paid as in-network	\$30 co-payment per visit, then 100% (deductible waived) 80% after deductible 75% after deductible	Not covered Not covered Paid as in-network	80% after deductible 80% after deductible 75% after deductible	Not covered Not covered Paid as in-network
Special Note about Hearing Services Benefit: Hearing screening tests of a newborn are covered under the Routine Preventive Care benefit						
<u>Behavioral Care (Includes Mental Health Care and Addictions Treatment)</u> 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 copayments may apply depending upon the type of service rendered		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or copayments 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	
<u>Infertility Treatment</u> \$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

Medical Plan Options—ASR Health Benefits

Miscellaneous Plan Provisions

Services Requiring Certification:

1. Inpatient hospital confinements and observational stays
2. Home and outpatient rehabilitative therapy
3. Durable medical equipment if the purchase price or forecasted total rental cost is \$2,500 or more
4. Home health care
5. Custom-made orthotic or prosthetic appliances if the purchase price is \$2,500 or more
6. Oncology treatment
7. Infusion or injection of select products (a list of the products can be accessed by logging on to www.asrhealthbenefits.com or by calling ASR Health Benefits at 800-968-2449)

If a covered person receives eligible treatment at an in-network facility, any anesthesia, 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.

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.

Medical Plan Options—ASR Health Benefits

Important Information about Eligible Retail Network Pharmacies

Covered prescription drugs obtained at a retail pharmacy must be filled at an eligible retail network pharmacy or else the drug purchase will not be eligible for coverage under the Plan. To find an eligible retail network pharmacy, the covered person can contact the Pharmacy Benefits Manager (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 pharmacies identified below will no longer be considered eligible retail network pharmacies for prescriptions:

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
- Public 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



Medical Plan Options—ASR Health Benefits

Benefit Description	Premier Plan Prescription Drug Benefit Description
<p>Prescription Drugs</p> <p>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.</p> <p>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.</p> <p>Specialty Prescription Drug Co-Payments (30-Day Supply)</p> <p>Prescription Drug Maximum Out-of-Pocket per Benefit Year</p>	<p>\$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</p> <p>\$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</p> <p>\$400/Specialty generic drugs, \$1,000/Specialty preferred drugs, \$1,500/Specialty non-preferred drugs</p> <p>Prescriptions for specialty prescription drugs must be filled through Lumicera Health Services specialty pharmacy or the drug will <u>not</u> be eligible for coverage under the Plan.</p> <p>\$2,800/person* \$5,600/family*</p>

*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:

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- Covered prescription drugs obtained at a retail pharmacy must be filled at an eligible retail network pharmacy or else the drug purchase will not be eligible for coverage under the Plan. For additional details, reference the important note about retail network pharmacies in this summary. The covered person can also contact the PBM using the information listed on the front of his/her identification card for assistance with finding an eligible retail network pharmacy.

Medical Plan Options—ASR Health Benefits

Benefit Description	Standard Plan Prescription Drug Benefit Description
<p>Prescription Drugs</p> <p>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.</p> <p>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.</p> <p>Specialty Prescription Drug Co-Payments (30-Day Supply)</p> <p>Prescription Drug Maximum Out-of-Pocket per Benefit Year</p>	<p>\$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</p> <p>\$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</p> <p>\$400/Specialty generic drugs, \$1,000/Specialty preferred drugs, \$1,500/Specialty non-preferred drugs</p> <p>Prescriptions for specialty prescription drugs must be filled through Lumicera Health Services specialty pharmacy or the drug will <u>not</u> be eligible for coverage under the Plan.</p> <p>\$1,800/person* \$3,600/family*</p>

*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:

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- Covered prescription drugs obtained at a retail pharmacy must be filled at an eligible retail network pharmacy or else the drug purchase will not be eligible for coverage under the Plan. For additional details, reference the important note about retail network pharmacies in this summary. The covered person can also contact the PBM using the information listed on the front of his/her identification card for assistance with finding an eligible retail network pharmacy.

Medical Plan Options—ASR Health Benefits

Benefit Description	High Deductible Health Plan Prescription Drug Benefit Description
<p>Prescription Drugs Covered Preventive Drugs* (30-Day Supply for Specialty Drugs, 90-Day Supply for All Other Eligible Drugs)</p> <p>*A drug is deemed "preventive" when it is taken by an individual who has developed risk factors for the disease that has not yet become clinically apparent, or to prevent the recurrence of a disease after the individual's recovery. The Pharmacy Benefits Manager (PBM) has developed and maintains a standard list of preventive drugs. If a Participant takes a preventive prescription drug that the PBM does not categorize as preventive, he or she should submit a written override request to the Plan Administrator. The Plan Administrator, by its authorized agent, will review the override request to determine if the U.S. Food and Drug Administration (FDA) has approved the drug to be prescribed for preventive purposes; if it has, the prescription/refill may be covered as a preventive prescription drug for purposes of the Plan.</p> <p>Covered Non-Preventive Drugs Purchased Before the In-Network Deductible is Satisfied</p> <p>Drugs Purchased <u>After</u> the In-Network Deductible is Satisfied</p> <ul style="list-style-type: none"> • Retail Prescription Drug Co-payments (90-Day Supply) • Mail-Order Prescription Drug Co-payments (90-Day Supply) • Specialty Prescription Drug Co-Payments (30-Day Supply) <p>Drugs Purchased <u>After</u> the In-Network Total Maximum Out-of-Pocket is Satisfied</p>	<p>20% of the purchase price/Formulary preventive prescription drug; No deductible applies</p> <p>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.</p> <p>20% of the purchase price/Formulary prescription drug</p> <p>20% of the purchase price/Formulary prescription drug</p> <p>20% of the purchase price/Formulary prescription drug</p> <p>Prescriptions for specialty prescription drugs must be filled through Lumicera Health Services specialty pharmacy or the drug will <u>not</u> be eligible for coverage under the Plan.</p> <p>Plan pays 100% of the purchase price; no co-payment applies</p>

*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. 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. Covered prescription drugs obtained at a retail pharmacy must be filled at an eligible retail network pharmacy or else the drug purchase will not be eligible for coverage under the Plan. For additional details, reference the important note about retail network pharmacies in this summary. The covered person can also contact the PBM using the information listed on the front of his/her identification card for assistance with finding an eligible retail network pharmacy.

Dental and Vision—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 kept 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
<u>Benefit Percentage</u>	
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	\$1,100
Claims for Type I Preventive Dental Services incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	
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.
<u>Vision Supply Expenses</u>	
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 Vision Supply Expenses	\$250

Flexible Spending Accounts—ASR Health Benefits

Flexible Spending Accounts

You have the opportunity to enroll in a flexible spending account (FSA) through Section 125 of the Internal Revenue Code. FSAs are an employer-established benefit plan that are funded with pretax contributions by employees. The IRS sets a maximum amount of money that you can contribute to an FSA and your employer may set a minimum contribution amount. FSAs abide by the “use-it or lose-it” rule which states any unspent funds remaining at the end of the plan year will revert back to the plan, not to you.

Healthcare FSA

Healthcare FSAs cover eligible healthcare expenses not reimbursed by an medical, dental, vision, or hearing care plan you or your dependents may have (excluding insurance premiums). An employer may set the annual maximum contribution no higher than \$2,700 per federal law. You may submit claims for yourself and your eligible dependents, including spouse, children, and any other person who is a qualified IRS dependent.

The healthcare 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 flexible spending reimbursement form. The form and a copy of the itemized bill (which must include the description of service, date of service, amount charged, amount insurance has paid, and amount you owe) should be submitted to ASR Health Benefits, who will then issue you a check.

Alternatively, your employer offers a Benefits (debit) Card. You can manage your account at www.asrhealthbenefits.com. Your annual election will be loaded on the debit card on July 1. You may use the card to pay for eligible expenses rather than submitting a form for reimbursement. ASR may request a copy of the itemized bill for the charge if it cannot be substantiated internally.

Limited Purpose Healthcare FSA

If you participate in the High Deductible Health Plan and contribute to an Health Savings Account (HSA), you may only be reimbursed through a Healthcare FSA for dental, vision, and hearing expenses. Medical expenses can only be reimbursed once your medical insurance deductible has been satisfied. Further, you cannot submit claims to both the Healthcare FSA and HSA.

Eligible Expense Examples:

Acupuncture
Alcohol or drug treatment
Ambulances
Birth control
Body scans
Chiropractor visits
Contact Lenses
Crutches
Deductibles, coinsurance, copays
Dental cleanings
Diagnostic tests
Durable medical equipment
Eyeglasses

Hearing aids
Immunizations
Lab fees
Lasic eye surgery
Over-the-counter drugs/supplements (if prescribed by a doctor)
Physical Therapy
Prescription Drugs
Smoking cessation aids
Surgery expenses
X-rays
Etc.

For a complete list of eligible and ineligible expenses, refer to Internal Revenue Publication 502 at www.irs.gov.

Ineligible Expense Examples

Bottled water
Cosmetics, toiletries, toothpaste
Food for weight-loss programs
Funeral and burial expenses
Health club dues
Insurance premiums
Long-term care
Marriage or family counseling
Maternity clothes, diaper service
Vitamins for general health purposes
Etc.

Flexible Spending Accounts—ASR Health Benefits

Dependent Care FSA

The dependent Care FSA allows you to use pretax dollars to pay for eligible child care or adult care for senior citizen dependents that live with you. Federal law 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 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 tax credit. It is advisable that you participate in either the dependent care FSA or claim the tax credit.

Dependent care expenses are expenses you incur that enable you to work. If you are married, the expenses must be incurred to allow both you and your spouse to work or 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 deposited and reimbursed is the lowest of your earned income, your spouse's earned income, or \$5,000 (\$2,500 if you are married and file separate tax returns). If your spouse's earned income is assumed to be not less than \$250 if you provide care for one dependent or \$500 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.

The dependent care 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 dependent care expenses. Withdrawals from the account are made using a flexible spending reimbursement form. The form and a copy of the itemized bill should be submitted to ASR Health Benefits, who will then issue you a check.

Alternatively, your employer offers a Benefits (debit) Card. You can manage your account at www.asrhealthbenefits.com. Your annual election will be loaded on the debit card on July 1. You may use the card to pay for eligible expenses rather than submitting a form for reimbursement. ASR may request a copy of the itemized bill for the charge if it cannot be substantiated internally.

Flexible Spending Debit Card

You may use the ASR flexible spending debit card to pay for eligible FSA expenses. Your card can be accepted at many service providers and merchandises where FSA-eligible expenses can be purchased, including hospitals, doctor offices, dental offices, pharmacies, and even some daycare centers.

By law merchants may require a signature debit or personal identification (PIN) debit. If you do not have a PIN or forget your PIN, the merchant can run the transaction as a signature or require another form of payment. You may obtain your pin by calling (866) 898-9795. You may reset your PIN by calling this number or call if your card is lost or stolen. You are unable to make cash withdrawals with this card. Expenses paid for with the debit card cannot also be reimbursed by a check.

Many merchants have an inventory information approval system (IIAS) in place to ensure FSA debit cards are only used for eligible expenses. Because many items at participating stores will be identified as eligible, you will not be required to substantiate the claim with a receipt. If you purchase an ineligible expense, you will be required to write a personal check to reimburse your FSA account or the amount will be deducted from a future claim request.

Over-the-counter items like ban-aids and blood sugar test kits will go through if the merchant has a IIAS in place, however OTC items such as Prilosec or Fish Oil will need to be submitted for reimbursement with a prescription from your doctor.



Grace Period

Your FSA has a two and a half month grace period at the end of the plan year. It is a period of time when you may incur qualified medical expenses and use remaining funds from the previous plan year. You will have 90 days after the grace period to submit those claims at the close of the two and a half months. If you end your participation in the healthcare FSA before the plan year ends, the grace period is unavailable.

Example: Plan year runs 7/1/19-6/30/20. You have \$100 left in your FSA as of 6/30. You have until 9/15/20 to incur \$100 worth of expenses. Those expenses need to be submitted for reimbursement by 12/15/20

Health Savings Account

If you are enrolled in the High Deductible Health Plan, you are eligible to open and participate in 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 establish at a financial institution of your choice. You will need to complete the HSA Response Form upon opening your HSA and return it to Human Resources.

HSA funds can be used for eligible out-of-pocket medical, dental, vision, and hearing expenses. Unlike the FSA, unused funds rollover from year to year and can earn interest tax-free.

You CANNOT use HSA funds for items that have been paid for or have been reimbursed by a Flexible Spending Account. For additional information, consult your tax advisor or visit www.treas.gov.

2019 Annual HSA Contribution Maximums

Single: \$3,500

Family: 7,000

Employees that are age 55 or older may contribute an additional \$1,000.

If you are enrolled in Medicare Part A and/or B, you cannot contribute pre-tax dollars to your HSA. You may use any remaining HSA funds for eligible medical expenses.

2019-2020 Wellness Rewards Program

PREMIUM REWARD

To receive the full wellness reward on health insurance premiums effective July 1, 2019, all employees must complete the following two requirements:

1. Complete the personal wellness assessment on the FitThumb e-wellness platform in February (participating spouses must also complete)
2. Attend a town hall meeting (or sign an online acknowledgement) in March

PLEASE NOTE:

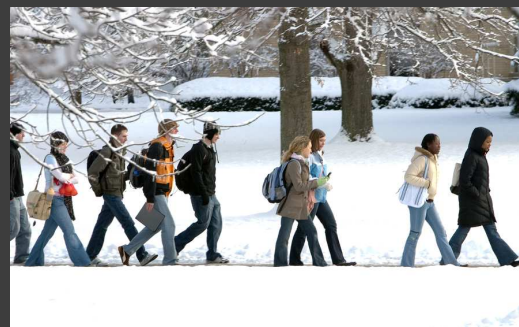
There will be no partial credit or subsequent opportunity to earn partial year credit.

If both requirements have been completed, you will be able to confirm that you have earned your full reward in the bswift system when you go through the online open enrollment process in April.

2020-2021 PLAN YEAR

The following requirements need to be completed by February 29, 2020 by both the employee and their participating spouse in order to receive the full wellness reward on health insurance premiums effective July 1, 2020:

- Health Risk Assessment
- Required number of points input into FitThumb
- Physical
- Attendance to a Town hall meeting or sign an online acknowledgement of changes to the health plan (required for employee only).



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.

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Standard Features

Eligibility	All eligible employees in active employment in the United States with the Employer.
Who pays for the cost of coverage?	<p>Your Basic Benefit</p> <ul style="list-style-type: none"> Your employer pays the cost of your coverage <p>Your Additional Benefit</p> <ul style="list-style-type: none"> You pay the cost of your coverage <p>Base Coverage for your Dependents</p> <ul style="list-style-type: none"> Your employer pays the cost of coverage for your spouse and children <p>Additional Coverage for your Dependents</p> <ul style="list-style-type: none"> You pay the cost of coverage for your spouse and children
Base Life coverage for You	<p>Base Life Benefit Amount</p> <ul style="list-style-type: none"> \$100,000 <p>Non-Medical Maximum</p> <ul style="list-style-type: none"> \$100,000 <p>All amounts are rounded to the next higher multiple of \$1,000, if not already an exact multiple thereof.</p>
Additional Life and Accidental Death & Dismemberment coverage for You	<p>Additional Life Benefit Options</p> <ul style="list-style-type: none"> 7x annual earnings, rounded to the next higher multiple of \$10,000, if not already an exact multiple thereof; or \$750,000 <p>Additional AD&D Benefit Options</p> <ul style="list-style-type: none"> 7x annual earnings, rounded to the next higher multiple of \$10,000, if not already an exact multiple thereof; or \$750,000 <p>Non-Medical Maximum</p> <ul style="list-style-type: none"> The lesser of 3x annual earnings or \$250,000 <p>All amounts are rounded to the next higher multiple of \$1,000, if not already an exact multiple thereof.</p>
Base Life coverage for your dependents	<p>Base Spouse Life Benefit Options</p> <ul style="list-style-type: none"> \$50,000 <p>Non-Medical Maximum</p> <ul style="list-style-type: none"> \$50,000 <p>Base Child Benefit Options</p> <ul style="list-style-type: none"> Live birth but under the age 19 years \$10,000 <p>Dependent Child Age Limit(s)</p> <ul style="list-style-type: none"> 19 years 25 if a full-time student <p><i>*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.</i></p>

Standard Features	
<p>Additional Life & Accidental Death & Dismemberment coverage for your dependents</p>	<p>Additional Spouse Life Benefit Options</p> <ul style="list-style-type: none"> • Amounts in \$5,000 benefit units to an overall maximum of \$250,000 as applied for by you and approved by Unum <p>Non-Medical Maximum</p> <ul style="list-style-type: none"> • \$50,000 <p>Additional Spouse AD&D Benefit Options</p> <ul style="list-style-type: none"> • Amounts in \$5,000 benefit units to an overall maximum of \$250,000 as applied for by you and approved by Unum <p>Additional Child Life Benefit Options</p> <p>Live birth but under the age 19 years</p> <ul style="list-style-type: none"> • Amounts in \$5,000 benefit units to an overall maximum of \$25,000 as applied for by you and approved by Unum <p>Additional Child AD&D Benefit Options</p> <p>Live birth but under the age 19 years</p> <ul style="list-style-type: none"> • Amounts in \$5,000 benefit units to an overall maximum of \$25,000 as applied for by you and approved by Unum <p>Dependent Child Age Limit(s)</p> <ul style="list-style-type: none"> • 19 years • 25 if a full-time student <p><i>*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.</i></p>
<p>AD&D Covered Losses and Benefits</p>	<p>Benefit Amount (For loss of):</p> <p>Full Benefit</p> <ul style="list-style-type: none"> • 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 <p>Half Benefit</p> <ul style="list-style-type: none"> • One hand or one foot • Sight of one eye • Speech or hearing <p>Quarter Benefit</p> <ul style="list-style-type: none"> • Thumb and index finger of the same hand
<p>AD&D Education Benefit</p>	<p>An additional lump sum benefit, to each qualified child (provided death occurs within 365 days of the accidental bodily injury), equal to the lesser of:</p> <ul style="list-style-type: none"> • 6% of the employee's AD&D benefit amount, or • \$6,000 <p>Maximum benefit payment 4 per lifetime. Maximum benefit amount \$24,000. Maximum benefit period 6 years from the date of the first benefit payment.</p>
<p>AD&D Repatriation Benefit</p>	<p>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.</p>

Standard Features	
AD&D Seatbelt and Airbag Benefit	<p>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.</p> <p>Benefit Amount:</p> <ul style="list-style-type: none"> • Seatbelt: 10% of the full amount of your AD&D benefit • Airbag: 5% of the full amount of your AD&D benefit <p>Maximum Benefit:</p> <ul style="list-style-type: none"> • 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	<p>AD&D benefits are excluded (not paid) for losses caused by, contributed to by, or resulting from:</p> <ul style="list-style-type: none"> • 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	<p>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.</p> <p>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.</p> <p>"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.</p>

Long Term Disability—Unum

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.

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Standard Features	
Eligibility	All eligible Full-Time Employees in active employment in the United States with the Employer.
Monthly Benefit Amount	<p>The monthly benefit will be the lesser of:</p> <ul style="list-style-type: none"> • 66.67% of monthly earnings; or • a maximum monthly benefit of \$6,000 <p>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.</p>
Minimum Monthly Benefit	<p>An amount equal to the greater of:</p> <ul style="list-style-type: none"> • \$100; or • 10% of your gross disability payment.
Elimination Period	<p>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.</p> <p>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.</p> <p>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.</p>
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	<p>2 Year Own Occupation with Residual</p> <p>You are disabled when Unum determines that:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>You must be under the regular care of a physician in order to be considered disabled.</p>
Survivor Benefit	<p>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:</p> <ul style="list-style-type: none"> • your disability had continued for 180 or more consecutive days; and • you were receiving or were entitled to receive payments under the plan.

Long Term Disability—Unum

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Standard Features

Rehabilitation and Return to Work Services	<p>The rehabilitation program may include, but is not limited to, the following services and benefits:</p> <ul style="list-style-type: none"> • 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	<p>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:</p> <ul style="list-style-type: none"> • you are participating in the Rehabilitation and Return to Work Assistance program; and • you are not able to find employment.

Exclusions & Limitations

Pre-existing Condition	<p>You have a pre-existing condition if:</p> <ul style="list-style-type: none"> • 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	<p>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:</p> <ul style="list-style-type: none"> • are not continuous; and/or • are not related. <p>Payments would continue beyond 24 months if you are confined to a hospital or institution as a result of the disability.</p>
Coverage Exclusions	<p>Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>

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.

800-872-1414

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.

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Employee Assistance Program (EAP) - Unum

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

* 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.

unum.com

The Work-life Balance Employee Assistance 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.

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Voluntary Short Term Disability—Unum

Disability benefits can help keep your bank 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 is at risk?

- Nearly 27 million Americans suffer disabling injuries each year
- Most disabilities are not work-related, therefore not covered by worker's compensation.
- 38% of workers could pay their bills for less than 3 months 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. You can keep it even if you leave 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: This is included at no extra charge for covered injuries and illnesses. This means you don't have to pay your premiums after 90 days of total disability or the elimination period (which ever is longer). They'll be waived as long as the disability continues, up to the maximum benefit period.

Checklist:

Expenses you may choose to cover with your disability benefits:

- Mortgage/Rent
- Transportation
- Utilities
- Childcare
- Loans/credit card debt

My Short Term Disability Coverage

Amount I applied for: \$ _____

Cost per pay period: \$ _____

Date deductions begin: ____/____/____

(For your records—complete during your benefit enrollment)

Policy Provisions:

- **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.
- **Pre-existing condition limitation:** If you have a pre-existing 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 in force.

* 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/received medical advice from a physician, or took prescribed medicine. The determination on whether your condition qualifies as preexisting will be based on the date of disability and not the date you notify Unum.

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

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.

Who is at risk?

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

Examples of covered injuries include:

You can choose from the following options:

- Broken bones
- Burns
- Torn ligaments
- Stitches
- Concussion
- Ruptured disc

Examples of covered expenses include:

- Emergency Room treatment
- Outpatient surgery facility
- Physical Therapy
- Doctor's office visit

Example of how accident coverage can help:

40 year old claimant falls at home resulting in a torn ACL

Expenses incurred (example):

\$100 ER copay
\$500 deductible
\$700 surgery costs
\$150 physical therapy copays

Benefits Paid (example):

\$150 ER visit
\$100 appliance (knee brace)
\$800 surgical ligament repair
\$150 Physical Therapy
\$75 follow up appointment

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 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.

The following benefits are automatically included in your plan:

Wellness Benefits: 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, mammograms

Catastrophic Benefits: 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.

Additional options:

Sickness Hospital confinement benefits: 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 child(ren) a daily benefit if he/she is in the hospital for a covered illness. The amount you receive can be \$100 per day, and 75% of the employee's amount for children. This benefit is available to family members who are covered by the base plan. There is an additional charge for this feature. There is a 12 month pre-existing condition limitation. Employees and their spouses need to answer certain health questions when applying for this benefit.

Who can have Accident coverage?

All eligible employees, their spouse ages 17-64 and dependent children up to their 26th birthday.

My Accident Coverage

Coverage Plan chosen: _____

Cost per pay period: \$ _____

Date deductions begin: ____/____/____

(For your records. Complete during your benefit enrollment)

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.

Who is 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
- Every 40 seconds, someone in America will have a stroke

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.

My Critical Illness Coverage

Amount I applied for: \$ _____

Cost per pay period: \$ _____

Date deductions begin: ____/____/____

(For your records. Complete during your benefit enrollment)

Examples of covered illnesses:

- Heart attack
- Stroke
- Major organ failure
- Occupational HIV
- Coma
- Blindness

If selected by your employer, you may choose to select this benefit for an additional premium:

- Cancer

The following is 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 (blood test, stress test, colonoscopy, chest x-ray, mammogram).

If you have other policies with a wellness benefit feature, you can receive a total of one benefit payment per year. A complete 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.

Who can have Critical Illness Coverage?	Benefit
Employees who are actively at work	\$5,000 to \$50,000 in \$1,000 increments
Spouses age 17 through 64 with purchase of employee coverage	\$5,000 to \$30,000 in \$1,000 increments
Dependent Children up to age 26. Children are automatically covered at 25% of the employee benefit at no additional cost	Covered for the same conditions as the employee and these childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, down syndrome and spinal bifida. Diagnosis must occur after the coverage effective date

Everyone's life insurance needs are different. 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.

Interest sensitive Whole Life Insurance

- **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).
- **Continuation Rider** available that will double the Long-Term Care benefit duration (paid out evenly over the course of 32-50 months)
- **Restoration Rider** available (after death benefit has exhausted due to Long-Term Care benefits, this rider restores 100% of death benefit)
- **Continuation/Restoration Rider Combination** is 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.



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

Life Changes

If you or your dependents experience a qualifying life event, you may be allowed to make certain benefit changes. The benefit change must be consistent with the event that prompts the change. In general, your life event effective date will be the first day that coverage is needed or the first date the coverage is not needed.

The change must be requested within 30 days of the qualifying event date. If a request to make a change happens beyond 30 days, it will be denied and you will not be able to make a change until the next Annual Open Enrollment Period.

Life Events:

- Marriage
- Divorce
- Birth/Adoption of a child
- Your spouse has an employment/coverage change resulting in a loss of coverage
- Your child is no longer eligible
- You take an unpaid leave of absence
- Death of a spouse/child

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.empowermyretirement.com, providing secure 24-hour online access to your account and investment information
2. Call 855-756-4738 to speak with a Participant Services Representative between 6:00 AM and 8:00 PM MT, Monday through Friday
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 receive. If you are interested in meeting with the Empower Retirement Education Counselor during one of their monthly visits to the university, you may arrange a one-on-one meeting by contacting them directly. They will be happy to answer your questions and work with you to develop an investment strategy that will meet your retirement needs.

Counselor: Michael Faulk

Email: michael.faulk@empower-retirement.com

Phone: 317-608-8590

Auto-Enroll: The ARP has an automatic enrollment feature for all newly hired employees whereby a 3% employee contribution is applied starting with the first paycheck. You must notify Empower Retirement if you want to opt-out of the ARP's auto-enroll and receive a refund of any salary reduction contributions made within the first 90 days of your employment.

Auto-Escalation: If your employee voluntary contribution level is under 7%, it will increase by 1% each July until your contribution reaches 7%. You may choose a different level or notify Empower Retirement that you want to opt-out of this plan feature; this must be done each year.

To make changes to your elections and beneficiaries, log on to the Empower Retirement website.

Tuition Assistance for Dependent Children

If you are a full-time, regular employee and have unmarried dependent children who are less than 24 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. 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:

- **Hourly Employees:** 35% of basic tuition costs for the child(ren) attending a local SDA church elementary school, a Lake Union Conference day academy, or an undergraduate program of Andrews University as a day/village student.
- **Salaried Employees:** 35% of basic tuition costs for the child(ren) attending a local SDA church elementary school, a Lake Union Conference day academy, an undergraduate program of Andrews University as a day student, or (for approved positions) an undergraduate program at other North American Division schools
- **For all employees:** 60% 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(ren)'s 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.

Free Class

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 - 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
1 through 4 years	0-7,488	25	200 hours	0.0961538
5 through 9 years	7,489 to 16,848	30	240 hours	0.1153846
Starting 10th 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
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving (1.5)
- Christmas (1.5)

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.

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/hr
Medical/Vision/Dental Plan PhysiciansCare (ASR Health Benefits) Medical/dental/vision claims, coverage, find a doctor	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
University Wellness	Dominique Gummelt T: 269.471.6165 www.andrews.edu/wellness wellness@andrews.edu
Networks While Traveling CIGNA Network Multiplan	www.cigna.com www.multipan.com
Pharmaceutical Plan Navitus NoviXus	T: 866.333.2757 www.navitus.com T: 877.668.4987
Retirement Empower Retirement	Michael Faulk T: 317.608.8590 michael.faulk@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 /AD&D—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



Andrews University

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