

2021/2022
Employee Benefit Guide



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The 2021-2022 benefits guide is a 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.

Contacts

Andrews University Benefits Department	T: 269.471.3886 www.andrews.edu/hr benefits@andrews.edu
ASR Health Benefits <i>Medical, Dental, Vision, FSA Claims, coverage, find a doctor, etc.</i>	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: <i>Cigna, Multiplan</i>	www.cigna.com, www.multiplan.com
Global Healthcare – Akeso Care Management	T: 866.232.8677
Pharmaceutical Plan <i>Navitus NoviXus</i>	T: 866.333.2757 www.navitus.com T: 877.668.4987
DenteMax Dental Network	T: 800.752.1547 www.dentemax.com
Employer Sponsored & Supplemental Life/AD&D <i>Unum (Contact AU Benefits Office)</i>	T: 800.421.0344
Unum Long Term Disability	T: 866.679.3057 www.unum.com
Unum <i>Voluntary Short-Term Disability, Accident, Critical Illness</i>	T: 800.635.5597 www.unum.com
Employee Assistance Program <i>Unum</i>	T: 800.854.1446 www.unum.com/lifebalance
Travel Assistance: <i>Assist America</i> <i>Reference #: 01-AA-UN-762490</i>	T: 800.872.1414 International: 301.656.4152
Free Class and Tuition Assistance	T: 269.471.3886 benefits@andrews.edu
Retirement <i>Empowerment Retirement</i>	Suzanne McHugh and Brian Hand T: 240.224.4911 (Suzanne), 720.701.2039 (Brian) suzanne.mchugh@empower-retirement.com brian.hand@empower-retirement.com
Auto Insurance <i>Liberty Mutual</i>	Neal Boff T: 269.569.7194 opt 1 or 269.327.2006 x 57071 Neil.boff@libertymutual.com
Short Term Travel Adventist Risk Management	T: 888.951.4ARM (4276)

Andrews University strives to provide you and your family with a comprehensive and valuable benefits package. If you have any questions regarding the benefits mentioned in this guide, please do not hesitate to reach out to Human Resources.

Benefit Eligibility

All regularly appointed employees working at least 20 hours per week or 50% are considered benefits eligible.

The following benefits are available to those working a minimum number of hours each week:

- Medical: 30 hours
- Dental/Vision: 30 hours
- FSA/Limited Purpose FSA: 30 hours
- HSA: 30 hours
- Employer Sponsored Life: 20 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: 20 hours
- Voluntary Critical Illness: 20 hours
- Whole Life: 20 hours
- Time-off, Tuition Assistance, Retirement, Free class: See pages 35-37

Employees eligible for health insurance may cover the following family members for medical, dental, and vision benefits:

- Your spouse by marriage with the following exception: If your spouse is a full-time employee with access to their own group sponsored healthcare benefits, he/she is not eligible to enroll as a dependent under the Andrews University Medical plan. This exception does not apply to Dental/Vision.
- Dependent children by birth, adoption, marriage, or legal guardianship.

How to Enroll

Begin reviewing your plan options in this benefit guide. All benefit selections need to be made online via bswift. To access bswift, visit www.andrews.edu/go/mybenefits. You will need to log in and you can begin the enrollment process by clicking “Enroll Now.” Once your enrollment is complete, review your elections via your confirmation statement. Please print and/or email yourself a copy for your records. If you are not making changes to your current elections, you do not need to log in UNLESS you are participating in a Flexible Spending Account. FSA elections do NOT roll over from year to year, so you will need to log in and make a new selection.

When to Enroll

The Open Enrollment period runs from April 1 through April 15. The benefits you choose during Open Enrollment will become effective on July 1, 2021.

Changes Outside of Open Enrollment

Unless you experience a qualified life event, you are not able to make changes to your benefits until the next Open Enrollment period. You have 30 days from your qualifying event to request a corresponding change to your benefits. Qualifying events include:

- Marriage
- Divorce
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse or dependent child
- Change in employment status for self, spouse, or child
- Change in coverage status under another employer-sponsored plan that creates a gain or loss of coverage for self, spouse, or child

New Hire/Newly Benefit Eligible

Newly hired or newly benefit eligible employees must log into bswift to make benefit selections within 30 days of your hire or benefit eligibility date.

Andrews Login

User Name

@andrews.edu

Password

Login

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	
<u>Comprehensive Medical Benefit</u> 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
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	Not applicable to this plan option; refer to the Total Maximum Out-of-Pocket stated below
Total Maximum Out-of-Pocket per Benefit Year	\$4,350/person \$8,700/family	Not applicable	\$5,350/person \$10,700/family	Not applicable	\$4,250/single \$8,500/family	\$8,000/single \$16,000/family
	Special Notes about the Comprehensive Medical Benefit: 1. An individual within a family has to meet only the per-person deductible specified above before the Plan will begin paying benefits. Additionally, an individual within a family has to meet only the per-person Coinsurance Maximum Out-of-Pocket before the Plan's general benefit percentage will increase to 100% for the remainder of the Benefit Year for the applicable benefit tier or the per-person Total Maximum Out-of-Pocket for In-Network charges before medical co-payments will no longer be charged for the remainder of the Benefit Year. Only charges billed by in-network providers will accrue toward the deductible and Coinsurance Maximum Out-of-Pocket for in-network services, and only charges billed by out-of-network providers will accrue toward the deductible and Coinsurance Maximum Out-of-Pocket for out-of-network services. 2. The Total Maximum Out-of-Pocket amounts include deductible, coinsurance, and medical co-payments. These amounts do not include prescription drug co-payments or medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the usual and customary charge, exceed limits of the Plan, or are otherwise excluded. Only charges billed by in-network providers will accrue toward the Total Maximum Out-of-Pocket for in-network services. Prescription drug co-payments 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).		Special Notes about the Comprehensive Medical Benefit: 1. An individual within a family has to meet only the per-person deductible specified above before the Plan will begin paying benefits. Additionally, an individual within a family has to meet only the per-person Coinsurance Maximum Out-of-Pocket before the Plan's general benefit percentage will increase to 100% for the remainder of the Benefit Year for the applicable benefit tier or the per-person Total Maximum Out-of-Pocket for In-Network charges before medical co-payments will no longer be charged for the remainder of the Benefit Year. Only charges billed by in-network providers will accrue toward the deductible and Coinsurance Maximum Out-of-Pocket for in-network services, and only charges billed by out-of-network providers will accrue toward the deductible and Coinsurance Maximum Out-of-Pocket for out-of-network services. 2. The Total Maximum Out-of-Pocket amounts include deductible, coinsurance, and medical co-payments. These amounts do not include prescription drug co-payments or medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the usual and customary charge, exceed limits of the Plan, or are otherwise excluded. Only charges billed by in-network providers will accrue toward the Total Maximum Out-of-Pocket for in-network services. Prescription drug co-payments 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).		Special Notes about the Comprehensive Medical Benefit: 1. 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 in a family. 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. However, an individual within a family has to meet only the per-person Total Maximum Out-of-Pocket before the Plan's general benefit percentage will increase to 100% for the applicable benefit tier. Medical and prescription drug co-payments will no longer be charged for the remainder of the Benefit Year after the applicable In-Network Total Maximum Out-of-Pocket is satisfied. 2. The Total Maximum Out-of-Pocket amounts include deductible, coinsurance, medical co-payments, and prescription drug co-payments. These amounts do not include medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the usual and customary charge, exceed limits of the Plan, or are otherwise excluded. Only charges billed by in-network providers will accrue toward the Total Maximum Out-of-Pocket for in-network services, and only charges billed by out-of-network providers will accrue toward the Total Maximum Out-of-Pocket for out-of-network services.	

Effective July 1, 2021

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Benefit Description	Premier Plan		Standard Plan		High Deductible Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<u>Outpatient Physician Services (Includes Office Visits, Telemedicine E-Visits, and Second Surgical Opinions)</u> Physician's Fee for an Examination All Other Charges Billed in Connection with the Examination	<i>Telemedicine E-Visits:</i> \$0 copayment per visit, then 100% (deductible waived) <i>Other Office Visits:</i> \$20 co-payment per visit, then 100% (deductible waived)	<i>Telemedicine E-Visits:</i> 60% after deductible <i>Other Office Visits:</i> 60% after deductible	<i>Telemedicine E-Visits:</i> \$0 copayment per visit, then 100% (deductible waived) <i>Other Office Visits:</i> \$30 co-payment per visit, then 100% (deductible waived)	<i>Telemedicine E-Visits:</i> 60% after deductible <i>Other Office Visits:</i> 60% after deductible	<i>Telemedicine E-Visits:</i> 80% after deductible <i>Other Office Visits:</i> 80% after deductible	<i>Telemedicine E-Visits:</i> 60% after deductible <i>Other Office Visits:</i> 60% after deductible
<u>Routine Preventive Care</u> Physician's Fee for an Examination Routine X-Rays and Lab Tests Flu Shots and Other Routine Immunizations FDA-Approved Contraceptive Methods and Sterilization Procedures for Women with Reproductive Capacity Mammograms, Colonoscopies, and Other Routine Services	100%; deductible waived	Not covered	100%; deductible waived	Not covered	100%; deductible waived	Not covered
<u>Urgent Care Center Visits</u> Physician's Fee for an Examination All Other Charges Billed in Connection with the Examination	\$75 co-payment per visit, then 100% (deductible waived) 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	60% after deductible 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	\$75 co-payment per visit, then 100% (deductible waived) 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	60% after deductible 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	80% after deductible 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	60% after deductible 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>Emergency Room Treatment</u> Hospital's Fee for the Use of the Emergency Room	\$250 co-payment* per visit, then 100% (deductible waived) *may waive if admitted	Paid as in-network	\$250 co-payment* per visit, then 100% (deductible waived) *may waive if admitted	Paid as in-network	80% after deductible	Paid as in-network

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Benefit Description	Premier Plan		Standard Plan		High Deductible Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Room Treatment, cont. All Other Charges Billed by the Hospital, Physician, or Any Other Provider in Connection with the Emergency Room Visit	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid as in-network	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid as in-network	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid as in-network
Ambulance Transportation	90% after deductible	Paid as in-network	80% after deductible	Paid as in-network	80% after deductible	Paid as in-network
Certification 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					
Inpatient Hospital Services Room and Board, Surgical Services, and Ancillary Services	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient Physician Services Hospital Visits, Surgical Procedures, and Anesthesiology	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Services Surgery and Surgery-Related Services Chemotherapy and Radiation Therapy Hemodialysis Durable Medical Equipment Prosthetics and Orthotics Diagnostic X-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
Allergy Services 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: 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. 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.						

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Benefit Description	Premier Plan		Standard Plan		High Deductible Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<u>Chiropractic Care</u> Spinal Manipulations, Therapy Treatments, and a Physician's Fee for an Initial or Periodic Evaluation <u>Diagnostic Spinal X-Rays</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)	\$20 co-payment per day, then 100% (deductible waived) 90% after deductible	\$20 co-payment per day, then 100% (deductible waived) Paid as in-network	\$30 co-payment per day, then 100% (deductible waived) 80% after deductible	\$30 co-payment per day, then 100% (deductible waived) Paid as in-network	80% after deductible 80% after deductible	Paid as in-network 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>Outpatient Rehabilitative Services</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
<u>Durable Medical Equipment, Prosthetics, and Orthotics</u>	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 co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
<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.						
<u>Convalescent Care and Home Health Care</u>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
<u>Hospice</u>	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible

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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 anesthesiology, pathology, or radiology charges will be paid at the in-network benefit percentage, even if out-of-network providers performed those services. However, charges in excess of the usual and customary limitation will not be eligible under the Plan.

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 for one of the reasons specified below, the claim may be adjusted to yield in-network-level benefits:

- A. There is not access to a Qualified in-network provider located within a Reasonable Distance from the covered person's residence.
- B. It was not reasonable for the covered person to seek care from an in-network provider because of a medical emergency.
- C. A covered person either traveled to a place where he or she could not reasonably be expected to know the location of the nearest in-network provider or traveled to a place where no in-network providers are available.
- D. A covered person receives eligible treatment at an in-network facility and he or she had no choice over the physician that provides treatment.

The term "Qualified" as used above means having the skills and equipment needed to adequately treat the covered person's condition. The term "Reasonable Distance" as used above approximates a 50-mile radius.

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 an automobile, claims will be processed in accordance with the Plan's position on that accident type.

IF A COVERED PERSON IS OPERATING A MOTORCYCLE AND IS INJURED IN AN ACCIDENT THAT DOES NOT INVOLVE AN AUTOMOBILE, 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 an automobile will not be subject to this provision and will not have his or her otherwise eligible claims excluded from Plan coverage as described above.

Special Eligibility Provision for Spouses Employed Full-Time

A participant's spouse who is eligible for coverage under his or her own employer's group medical plan as a full-time employee will not be eligible to participate in or be covered under this Plan.

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

The following exceptions to this provision shall apply:

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

Health Savings Account (HSA)

Individuals enrolled in this Plan may be eligible to establish and maintain a health savings account (HSA). The terms of the HSA are governed by Section 223 of the Internal Revenue Code and the terms of the trust or custodial agreement establishing the HSA. Funds contributed to an HSA are not subject to federal income tax at the time of deposit and can be rolled over and accumulated from year to year if not spent. HSA funds can be used to purchase qualified medical expenses, for example, the cost of a doctor's office visit or a prescription drug. In 2021, you may contribute up to **\$3,600** for single coverage or **\$7,200** for family coverage to an HSA. Additional catch-up contributions (**\$1,000**) may be made if you are age 55 or older.

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

Important Information about Eligible Network Pharmacies

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
- Publix Pharmacy
- TriNet Pharmacy
- American Pharmacy Network Solution
- Kmart Pharmacy
- H E B Pharmacy
- Hy-Vee Pharmacy
- Giant Eagle Pharmacy
- Shoprite Pharmacy
- SuperValu Pharmacy
- Delhaize Pharmacy
- Harris Teeter Pharmacy
- Brookshire Grocery Pharmacy.

Benefit Description	Premier Plan Prescription Drug Benefit Description
<p><u>Prescription Drugs</u></p> <p><u>Retail Prescription Drug Co-payments (30-Day Supply)</u> 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><u>Mail-Order Prescription Drug Co-payments (90-Day Supply)</u> 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><u>Prescription Drug Maximum Out-of-Pocket per Benefit Year</u></p>	<p>\$0/eligible OTC, \$10/Rx Formulary Preferred Tier 1 drug, \$20/Rx Formulary Non-Preferred Tier 1 drug, \$50/Rx Formulary Tier 2 drug, \$70/Rx Formulary Tier 3 drug</p> <p>Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply</p> <p>\$0/eligible OTC, \$25/Rx Formulary Preferred Tier 1 drug, \$50/Rx Formulary Non-Preferred Tier 1 drug, \$125/Rx Formulary Tier 2 drug, \$175/Rx Formulary Tier 3 drug</p> <p>Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply</p> <p>\$2,800/person* \$5,600/family*</p>
<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. An individual within a family has to meet only the per-person Prescription Drug Maximum Out-of-Pocket before prescription drug co-payments will no longer be charged for the remainder of the Benefit Year.</p>	

Effective July 1, 2021

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Benefit Description	Premier Plan Prescription Drug Benefit Description
<p>Special Notes about Prescription Drug Coverage:</p> <p>1. The Plan's Pharmacy Benefits Manager (PBM) maintains lists of preferred and non-preferred generic and brand-name prescription drugs, and a drug's co-payment is determined by the drug's categorization in these lists. The term "Rx Formulary Tier 1" generally means a category of prescription drugs that includes most generic drugs and may include some low-cost brand-name drugs (this category of prescription drugs is further separated into a Preferred and Non-Preferred drug list based on the purchase price of the prescription). The term "Rx Formulary Tier 2" means a category of prescription drugs that includes preferred brand-name drugs and may include some high-cost generic drugs. The term "Rx Formulary Tier 3" means a category of prescription drugs that generally includes all non-preferred drugs. For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the covered person can contact the PBM using the information shown on the front of his/her identification card.</p> <p>2. 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.</p> <p>3. Certain over-the-counter drugs 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.</p> <p>4. Prescription drugs for the treatment of infertility are eligible for coverage under the Plan, subject to the co-payments stated above. However, the Plan will only cover one 60-day supply per covered person, lifetime.</p> <p>5. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications, including, but not limited to, certain FDA-approved contraceptive agents and smoking cessation products with a prescription, as well as breast cancer medications that lower the risk of cancer or slow its development, without any cost-sharing provisions such as deductibles or co-payments. For more information about eligible preventive care medications, the covered person can contact the PBM using the information listed on the front of his/her identification card.</p> <p>6. Prescription drugs that are not on the formulary drug list maintained by the PBM are <u>not</u> 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.</p> <p>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 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.</p> <p>8. Covered prescription drugs obtained at a retail pharmacy must be filled at an eligible retail network pharmacy or else the drug purchase will <u>not</u> 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.</p> <p>9. The Plan generally provides coverage for certain Specialty Prescription Drugs as specified in the Prescription Agreement between the employer and the PBM; however, special rules may apply in order for such drugs to be covered. Covered persons prescribed a Specialty Prescription Drug should contact the PBM at the number on the identification card to learn about the special rules that may apply to the drug, including the co-payment that will be charged or other special coverage terms that will apply. As used in this benefit, the term "Specialty Prescription Drug" means a prescription 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 medications with 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.</p> <p>10. The Plan requires that a covered person purchase self-injectable medications through the Prescription Drugs benefit. For more information about self-injectable medications, the covered person can contact the PBM using the information shown on the front of his/her identification card.</p>	

Benefit Description	Standard Plan Prescription Drug Benefit Description
<p><u>Prescription Drugs</u></p> <p><u>Retail Prescription Drug Co-payments (30-Day Supply)</u> 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><u>Mail-Order Prescription Drug Co-payments (90-Day Supply)</u> 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><u>Prescription Drug Maximum Out-of-Pocket per Benefit Year</u></p>	<p>\$0/eligible OTC, \$10/Rx Formulary Preferred Tier 1 drug, \$20/Rx Formulary Non-Preferred Tier 1 drug, \$60/Rx Formulary Tier 2 drug, \$80/Rx Formulary Tier 3 drug</p> <p>Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply</p> <p>\$0/eligible OTC, \$25/Rx Formulary Preferred Tier 1 drug, \$50/Rx Formulary Non-Preferred Tier 1 drug, \$150/Rx Formulary Tier 2 drug, \$200/Rx Formulary Tier 3 drug</p> <p>Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply</p> <p>\$1,800/person* \$3,600/family*</p>
<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. An individual within a family has to meet only the per-person Prescription Drug Maximum Out-of-Pocket before prescription drug co-payments will no longer be charged for the remainder of the Benefit Year.</p>	

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Benefit Description	Standard Plan Prescription Drug Benefit Description
<p>Special Notes about Prescription Drug Coverage:</p> <ol style="list-style-type: none"> 1. The Plan's Pharmacy Benefits Manager (PBM) maintains lists of preferred and non-preferred generic and brand-name prescription drugs, and a drug's co-payment is determined by the drug's categorization in these lists. The term "Rx Formulary Tier 1" generally means a category of prescription drugs that includes most generic drugs and may include some low-cost brand-name drugs (this category of prescription drugs is further separated into a Preferred and Non-Preferred drug list based on the purchase price of the prescription). The term "Rx Formulary Tier 2" means a category of prescription drugs that includes preferred brand-name drugs and may include some high-cost generic drugs. The term "Rx Formulary Tier 3" means a category of prescription drugs that generally includes all non-preferred drugs. For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the covered person can contact the PBM using the information shown on the front of his/her identification card. 2. 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. 3. Certain over-the-counter drugs will be covered under the Plan and shall be subject to the co-payments shown above. A physician's prescription for these products is required. 4. Prescription drugs for the treatment of infertility are eligible for coverage under the Plan, subject to the co-payments stated above. However, the Plan will only cover one 60-day supply per covered person, lifetime. 5. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications, including, but not limited to, certain FDA-approved contraceptive agents and smoking cessation products with a prescription, as well as breast cancer medications that lower the risk of cancer or slow its development, without any cost-sharing provisions such as deductibles or co-payments. For more information about eligible preventive care medications, the covered person can contact the PBM using the information listed on the front of his/her identification card. 6. Prescription drugs that are not on the formulary drug list maintained by the PBM are <u>not</u> 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 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 <u>not</u> 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. 9. The Plan generally provides coverage for certain Specialty Prescription Drugs as specified in the Prescription Agreement between the employer and the PBM; however, special rules may apply in order for such drugs to be covered. Covered persons prescribed a Specialty Prescription Drug should contact the PBM at the number on the identification card to learn about the special rules that may apply to the drug, including the co-payment that will be charged or other special coverage terms that will apply. As used in this benefit, the term "Specialty Prescription Drug" means a prescription 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 medications with 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. 10. The Plan requires that a covered person purchase self-injectable medications through the Prescription Drugs benefit. For more information about self-injectable medications, the covered person can contact the PBM using the information shown on the front of his/her identification card. 	

Benefit Description	High Deductible Health Plan Prescription Drug Benefit
<p><u>Prescription Drugs</u> Covered Preventive Drugs* (30-Day Supply for Specialty Prescription 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>20% of the purchase price/Formulary preventive prescription drug; No deductible applies</p> <p>Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply</p>

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Benefit Description	High Deductible Health Plan Prescription Drug Benefit
<p>Prescription Drugs, cont.</p> <p>Covered Non-Preventive Drugs Purchased Before the In-Network Deductible is Satisfied</p> <p>Drugs Purchased After 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) <p>Drugs Purchased After the In-Network Total Maximum Out-of-Pocket is Satisfied</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>Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply</p> <p>20% of the purchase price/Formulary prescription drug</p> <p>Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply</p> <p>Plan pays 100% of the purchase price; no co-payment applies</p>
<p>Special Notes about Prescription Drug Coverage:</p> <ol style="list-style-type: none"> 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. Certain over-the-counter drugs will be covered under the Plan and shall be subject to the co-payments shown above after the in-network medical deductible has been met. After the in-network medical Total Maximum Out-of-Pocket is met, no co-payment shall apply for the rest of the Benefit Year. 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 after the in-network deductible has been met. 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 Pharmacy Benefits Manager (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 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. 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. The Plan generally provides coverage for certain Specialty Prescription Drugs as specified in the Prescription Agreement between the employer and the PBM; however, special rules may apply in order for such drugs to be covered. Covered persons prescribed a Specialty Prescription Drug should contact the PBM at the number on the identification card to learn about the special rules that may apply to the drug, including the co-payment that will be charged or other special coverage terms that will apply. As used in this benefit, the term "Specialty Prescription Drug" means a prescription 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 medications with 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. The Plan requires that a covered person purchase self-injectable medications through the Prescription Drugs benefit. For more information about self-injectable medications, the covered person can contact the PBM using the information shown on the front of his/her identification card. 	

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Coverage for dental and vision benefits comes as a combined package. Covered persons cannot elect coverage for one benefit type without the other.

Benefit Description	Dental Plan
	Limits (In-Network and Out-of-Network)
Benefit Year	July 1 through June 30
Deductible per Benefit Year	\$25/person \$75/family
Special Note about the Dental Deductible: An individual within a family has to meet only the per-person deductible specified above before the Plan will begin paying benefits for Type II, Type III, & Type IV dental services.	
<u>Benefit Percentage</u> Type I - Preventive Dental Services Type II - Minor Restorative Dental Services Type III - Major Restorative Dental Services Type IV - Orthodontic Services (for dependent children under age 24 only)	100%; deductible waived (0% coinsurance) 75% after deductible (25% coinsurance) 75% after deductible (25% coinsurance) 50% after deductible (50% coinsurance)
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II, and III Dental Services Claims for Type I Preventive Dental Services incurred by covered persons under age 19 are not subject to the Benefit Year dollar maximum.	\$1,100
Lifetime Maximum Benefit Paid per Dependent Child for Type IV Orthodontic Services	\$1,760

Benefit Description	Vision Plan
	Limits
Benefit Year	July 1 through June 30
Vision Examinations	\$15 co-payment* per exam, then 100% (0% coinsurance) *Eligible charges for routine vision exams for covered persons under age 19 will be paid at 100% and no co-payment shall apply.
<u>Vision Supply Expenses</u> Eyeglass Frames Eyeglass Lenses, Including Eyeglass Lens Add-Ons Such As Tinting, Ultraviolet Coatings, Scratch-Resistant Coatings, and Anti-Reflective Coatings Contact Lenses	100% (0% coinsurance) 100% (0% coinsurance) 100% (0% coinsurance)
Maximum Benefit Paid per Covered Person per Benefit Year for All Eligible Vision Supply Expenses	\$250

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Penalties Associated with the QHDHP and Medicare

Medicare Part D late enrollment penalty: You may experience Medicare Prescription (Part D) late enrollment penalties if you select our QHDHP plan. The late enrollment penalty is an amount added to your Medicare Part D monthly premium. You may owe a late enrollment penalty if, for any continuous period of 63 days or more after your Initial Enrollment Period is over, you go without “creditable coverage”.

For each month you delay enrollment in Medicare Part D, you will have to pay a 1% Part D late enrollment penalty (LEP), unless you:

- Have creditable drug coverage
- Qualify for the Extra Help program

How do you calculate your premium penalty? Example: you delayed enrollment in Part D for seven months (and you do not meet any of the exceptions listed above). Your monthly premium would be 7% higher for as long as you have Part D (7 months x 1%). The national base beneficiary premium in 2020 is \$32.74 a month. Your monthly premium penalty would be \$2.32 ($\$32.74 \times 1\% = \$0.3319 \times 7 = \2.32) per month, which you would pay in addition to your plan’s premium. This penalty never expires or goes away.

Benefit options for full-time employees over age 65: Full-time, benefit eligible employees have an alternative to a group sponsored healthcare plan. Medicare Advantage plans often have small copays and out of pocket cost share for members.

Advantage plans may also provide coverage for dental, vision and hearing services. You may also benefit from discounts on gym memberships and other perks. When it comes to Medicare and Medicare Advantage plans, few of us know facts from fiction. It’s always good to know your options.

Where can I get help?

Laurie De Ridder-Eppink, Coldbrook Insurance Group: Individual Life, Health, and Medicare Agent

Direct Line: (616)284-5901 / Toll-Free (800)434-5405 x 521

Fax: (616)419-2000

Email: lauried@coldbrookins.com

Office address: 45 Coldbrook, NW, Grand Rapids, MI 49503

Marci Rambo, Account Manager Phone: (616)301-6717

Social Security Office:

Location: 455 Bond Street, Benton Harbor, MI 49022

Phone: (877)405-5457

Hours: Monday, Tuesday, Thursday, Friday: 9:00 AM – 4:00 PM, Wednesday: 9:00 AM – 12:00 PM

Central County Center for Senior Citizens:

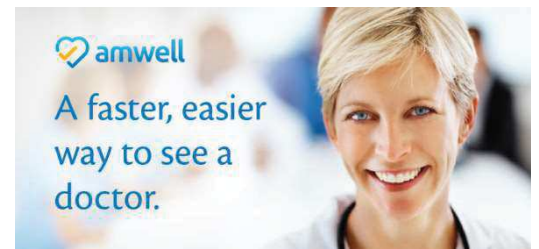
Location: 4083 East Shawnee / PO Box 252 Berrien Springs, MI 49103

Virtual Health – AmWell



Download the Amwell app or scan the QR code

App Store | Google play



ASR Participants can sign up with AmWell to connect with a certified provider anytime, anywhere. You can use AmWell when:

- You need to see a doctor, but can't fit it in with your schedule.
- You're traveling and forgot a prescription or need a doctor.
- You feel too sick to leave the house.
- You need to care for your children.
- Your doctor's office is closed.

Conditions Treated and Services:

- Cough, cold, and allergy
- Flu
- Sinusitis
- Headache/Migraines
- Upper respiratory infections
- Child Health Concerns
- Sore throat
- Fever
- Ear pain
- Urinary problems
- Pink eye and sty
- Burns
- Rashes and acne
- Prescription refills
- And more...

Sign up for AmWell; it's as easy as 1, 2, 3!

STEP 1: ENROLL

Visit www.amwell.com/cm, click on the **SIGN UP** button in the upper right corner, enter your name and e-mail address, create a password, and answer a few simple questions. **You will be required to enter a credit card even if there no copay responsibility.**

HDHP Plan Service Key = asrmemberpay

Premier & Standard Plan Service Key = asrcopaywaived

STEP 2: CHOOSE A DOCTOR

Click on the **URGENT CARE** icon, and then click on the green access button (🟢) for a doctor available now or the yellow access button (🟡) to wait in a

Visit www.amwell.com/cm when using a computer, download the Amwell mobile app, or call 1-844-733-3627

Medical Contributions

Contribution per Pay (24 pays)	Employee Only	Employee + 1	Employee +2 or more
Premier Plan	\$97 / \$202	\$144 / \$249	\$192 / \$297
Standard Plan	\$72 / \$177	\$109 / \$214	\$144 / \$249
High Deductible Health Plan	\$31 / \$58	\$53 / \$158	\$67 / \$172

*Bolded dollar amount indicates you have earned the wellness discount

Dental/Vision Contributions

Contribution per Pay (24 pays)	Employee Only	Employee + 1	Employee +2 or more
Dental/Vision	\$15	\$30	\$44

Wellness

July 1, 2021 Premium Reward: To receive the full wellness reward on health insurance premiums all employees must complete the following requirements. If completed, you will be able to confirm the reward in bswift when you go through the Open Enrollment process in April.

- **By February 28, 2021** Employee and participating spouse must complete the on-line Health Risk Assessment.
- **By March 26, 2021:** The employee must sign an online attestation form stating they have read the Employee Benefit Guide.

There will be no partial credit given

Dental Network – DenteMax

Why use DenteMax?

- **Access:** There are over 224,000 credentialed dentist access points nationwide
- **Quality:** Every DenteMax provider undergoes rigorous credentialing before they can join the network
- **Savings:** Reduce out-of-pocket costs, stretch your annual benefit maximums, and possibly even receive network discounts on services after your annual maximum has been reached

Find a provider: Visit www.dentemax.com or call customer service (800) 752-1547

Flexible Spending Accounts (FSA)

Andrews University is giving you the opportunity to enroll in an employee benefit plan called a flexible spending account (FSA) through Section 125 of the Internal Revenue Code. An FSA is an employer-established benefit plan that is generally funded with pretax contributions by employees. The Internal Revenue Service (IRS) sets a maximum amount of money that you can contribute to an FSA, and your employer may set a minimum contribution. The main disadvantage of an FSA is the use-or-lose rule, which states that any unspent funds remaining at the plan year's end will revert back to the plan, not to you. You may minimize this potential risk by allocating only enough pretax dollars to cover expenses that you expect to incur in the coming plan year.

Healthcare FSA (HCFSA): A medical FSA covers eligible health-care expenses not reimbursed by any medical, dental, or vision care plan you or your dependents may have (but not health insurance premiums). You may submit claims for yourself and your eligible dependents, including your spouse, children, and any other person who is a qualified IRS dependent. The medical FSA operates much like a bank account. Deposits are made into the account in the form of pretax payroll deductions. You can withdraw funds from the account to pay for qualified medical expenses even if you have not yet placed the funds in the account. Withdrawals from the account are made using a flex reimbursement form. You should submit the reimbursement form and a copy of your receipt or bill to ASR Health Benefits, who will then issue you a check. Alternatively, your Andrews offers a more convenient method of reimbursement; a Benefits (debit) Card (see description below). You can manage your account at www.asrhealthbenefits.com. Review your past medical expenses and plan your future needs carefully to decide if the medical FSA is right for you. Also, note the deductible, coinsurance, and co-payment amounts required in the health plan option that you have selected, as they can also be reimbursed from your medical FSA. For a complete list of eligible and ineligible medical expenses, refer to Internal Revenue Publication 502 at www.irs.gov.

The annual maximum contribution can be no higher than \$2,750 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.

Eligible Expenses			Ineligible Expenses
Acupuncture	Health care equipment	Sterilization	Bottled water
Alcoholism or drug treatment	Hearing aids	Surgery (general)	Cosmetics, toiletries, toothpaste, etc.
Ambulances	Hypnosis (for treatment of disease)	Syringes	Custodial care in an institution
Birth control	Immunizations	Teeth whitening (to correct discoloration caused by disease, birth defect, or injury)	Electrolysis
Body scans	Lab fees	Television (closed captioned)	Food for weight-loss programs
Car controls (handicapped equipment)	Lasik (Laser) eye surgery	Vitamins and minerals (prescription only)	Funeral and burial expenses
Chiropractors	Learning disabilities (instructional fees)	Weight loss programs (only as treatment for obesity, heart disease, or diabetes; includes fees and expenses)	Health club dues
Contact lenses	Lifetime care	Well-baby care	Household and domestic help
Cosmetic surgery (medically necessary)	Massage therapy (prescribed by a physician to treat a specific medical condition)	Wheelchairs	Insurance premiums
Crutches	Nursing services (medically necessary)	X-rays	Long-term care
Deductibles and co-payments	Optometrist's fees		Marriage or family counseling
Dental and vision expenses	Over-the-counter drugs (if prescribed to alleviate or treat illness or injury)		Maternity clothes, diaper services, etc.
Diagnostic tests (pregnancy tests, ovulation monitors, cholesterol and blood pressure tests)	Physical therapy		Meals and general lodging
Doctor's fees	Prescription drugs		Uniforms
Eyeglasses	Smoking cessation aids/programs		Vitamins taken for general health purposes
Guide dogs			

Limited Purpose Healthcare FSA: If you participate in the High Deductible Health Plan and contribute to a 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. The same \$2,750 contribution maximum applies to the Limited Purpose Healthcare FSA as the non-Limited Purpose Healthcare FSA.

FAQs on LIMITED-PURPOSE MEDICAL FSA

- **What is a limited-purpose medical flexible spending account (FSA)?** A limited-purpose medical FSA is identical to a general-purpose medical FSA, except that the qualifying medical expenses are limited to dental, vision, and hearing care (see eligible expenses on next page). **Medical expenses can only be reimbursed once your medical insurance deductible has been satisfied.**
- **Why is my employer offering a limited-purpose medical FSA?** Your employer is offering an HSA-qualifying high-deductible health plan (HDHP) for employees who want to open and contribute to an HSA. While contributing to an HSA, you must be enrolled in an HDHP, and you may not have any coverage that is not an HDHP. A general-purpose medical FSA is considered non-HDHP coverage, but a limited-purpose medical FSA is not. Therefore, a limited-purpose option is offered so you may contribute to an HSA. Benefits are limited to dental, vision, and preventive care as of the first day of the plan year you are covered by the medical FSA.
- **If I meet my deductible under the HDHP, may I use my medical FSA for any IRS-qualifying expense?** Yes. Once you have satisfied the HDHP deductible for a plan year, you may submit expenses to your medical FSA for any IRS-qualifying expenses for the remainder of the plan year. Please see your flex plan document for a list of those expenses.
- **What if my medical FSA has a grace period?** If you have a \$0 balance in your medical FSA as of the last day of the plan year, you are still HSA eligible, notwithstanding the grace period. Your balance at year-end is determined on a cash basis, taking into account only those expenses that have been incurred and paid as of year-end. Pending claims, claims submitted, claims received, or claims under review that have not been paid as of year-end are not taken into account when determining your year-end FSA balance. If you have a balance in your medical FSA, you may open and contribute to an HSA on the first calendar month after the end of the grace period.
- **Will I still be able to contribute the maximum allowed amount to my HSA if I have to wait until the first calendar month after the end of the grace period?** Yes. If you are HSA eligible for only a portion of the year, you may make a full year's worth of HSA contributions. For example, if you open your HSA on April 1, you may still contribute up to the statutory amount to your HSA.
- **What if my employer offers an HDHP option midyear, and I am enrolled in a general-purpose medical FSA?** You will not be eligible to open and contribute to an HSA until the next plan year begins, and you enroll in the limited-purpose medical FSA.
- **May I change my election to a limited-purpose medical FSA so I may enroll in the HDHP midyear and open an HSA?** No, this change is not permissible under the IRS regulations unless you have a change in status (e.g., marriage, divorce, birth of a child). The HDHP

Dependent Care FSA (DCFSA)

With the dependent care FSA, you can reduce your tax burden by using pretax dollars to pay expenses for eligible childcare or adult care for senior-citizen dependents that live with you. Federal law also allows you to claim a direct credit against federal income taxes for eligible child or dependent care expenses. However, any amount you claim under the dependent care tax credit will be reduced by the amount you are reimbursed under the dependent care FSA. The amount reimbursed under the dependent care FSA reduces, dollar-for-dollar, the amount of dependent care expenses that are eligible for the dependent care tax credit; therefore, you should either participate in the dependent care FSA to the fullest extent possible or claim the tax credit. The dependent care FSA operates much like a bank account. Deposits are made into the account in the form of pretax payroll deductions. Withdrawals from the account are made using a flex reimbursement form. You should submit the reimbursement form and a copy of your receipt or bill to ASR Health Benefits, who will then issue you a check. Alternatively, Andrews offers a more convenient method of reimbursement; a Benefits (debit) Card (see description below). You can manage your account at www.asrhealthbenefits.com. Dependent care expenses are expenses you incur to enable you to work. If you are married, the expenses must be incurred to enable you and your spouse to work, or to enable your spouse to attend school on a full-time basis. The expenses must be for the care of your dependent who is under age 13 and for whom a personal-exemption deduction is allowed for federal income tax purposes, for the care of your dependent or spouse who is physically or mentally incapable of self-care, or for household services in connection with the care of a qualifying dependent. The maximum amount that can be reimbursed (i.e., deposited) is the lowest of your earned income, your spouse's earned income, or \$5,000.00 (\$2,500.00 if you are married and you file a separate tax return). If your spouse is a full-time student or is incapable of self-care, your spouse's earned income is assumed to be not less than \$250.00 if you provide care for one dependent, or \$500.00 for two or more dependents, for each month that your spouse is a student or incapable of self-care. Please refer to Internal Revenue Publication 503 for more information on eligible and ineligible expenses at www.irs.gov.

Flexible Spending Debit Card

You may use the ASR Health Benefits Card to pay for eligible expenses with funds from your own medical or dependent care FSA at the time and place the expense is incurred. The ASR Health Benefits Card operates within the Visa® credit card network. Your card will be accepted at most service providers and merchants where FSA-eligible expenses can be purchased, including hospitals, doctors' offices, dental offices, optical stores, pharmacies, and even some day-care centers. By law, merchants may choose to require either a signature debit or a personal identification number (PIN) debit. If you do not have a PIN or forget your PIN, the merchant can run the transaction as a signature debit or require another form of payment. You may obtain your PIN or reset your PIN by calling (866) 898-9795. Your PIN is system generated and cannot be customized. You are unable to make cash withdrawals at ATMs or at stores that allow for cash back on PIN debit purchases. Note: Report a lost or stolen card by calling ASR's Plan Administration Department at (800) 968-2449. When you use your ASR Health Benefits Card, you will not have to pay for the expense, file substantiating documentation with a request for reimbursement, and then wait for the refund check to come. Most merchants have what is called an inventory information approval system (IIAS) in place to ensure FSA debit cards are used only for medical expenses that are FSA eligible. Examples of these merchants are drug stores, pharmacies, and grocery stores.

Because most items in these stores will be identified as FSA eligible through IIAS, you will not have to substantiate the FSA-eligible items that you purchase with your ASR Health Benefits Card. Make sure that you use your ASR Health Benefits Card only for FSA-eligible expenses! If you purchase an

ineligible item using your ASR Health Benefits Card, you will have to write a personal check to reimburse your FSA account, or the amount will be deducted from a future claim request. In order to purchase over-the-counter (OTC) medications with your ASR Health Benefits Card, you must present a prescription for an OTC medication to your pharmacy or your mail-order or Web-based vendor that dispenses the medication and retain proper records of the transaction. However, you may purchase non-medicine OTC items, such as bandages, blood sugar test kits, and test strips, with the ASR Health Benefits Card at merchants that have an IIAS in place, or you may purchase them manually, without a prescription.

Grace Period

Your medical FSA has a two and one-half month grace period at the end of the plan year. This grace period is a period of time when you may incur qualified medical expenses and pay them from any amounts left in your FSA at the end of the previous year. The grace period ends on the 15th day of the third month of the next plan year, but you will have a time period after that in which to submit (but not incur) the claims. You must forfeit any funds remaining in your FSA at the end of the grace period. Here is an example of how the grace period works:

Your plan year runs on a July 1 to June 30 basis and has a two and one-half month grace period. You have three months after the grace period to submit claims incurred during the plan year and the grace period. At the end of June 2021, you have \$250 left in your medical FSA. You incur \$250 of qualified medical expenses during July 1 through September 15 of 2021, the grace period for the 2020-21 plan year. You may submit these expenses by December 15, 2021 in order to receive reimbursement.

Healthcare Savings Accounts (HSA)

If you are enrolled in the high Deductible Health Plan (HDHP), you are eligible to open a Healthcare Savings Account (HSA).

You determine the amount to be deducted from each paycheck (if any) on a tax-free basis and deposited into an HSA that you open at the 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.

The maximum contribution to an HSA for a single person is \$3,600 and \$7,200 for a family. Employees aged 55 and over are able to contribute an additional \$1,000 total.

IMPORTANT: If you are enrolled in Medicare Part A and/or B, you CANNOT contribute pre-tax dollars into your HSA. You may use any funds leftover in your HSA for eligible, out-of-pocket medical, dental, vision, and hearing expenses, but you cannot continue to put pre-tax dollars in the account. If you are 65, you can also use any remaining HSA funds for your Medicare Parts A, B, D and Medicare HMO premiums.

Life and AD&D provided through Unum

Eligibility: All eligible employees in active employment in the United States with Andrews University

Who pays for the cost of coverage?

- **Basic Benefit:** Andrews University
- **Your Additional/Supplemental Benefit:** You
- **Base Coverage for your Spouse and/or Children:** Andrews University
- **Additional/Supplemental Coverage for your Spouse and/or Children:** You

Base Life Coverage for Employees:

- Base Life Benefit: \$100,000
- Non-Medical Maximum: \$100,000
- All amounts are rounded to the next higher multiple of \$1,000, if not already an exact multiple thereof

Additional Life and Accidental Death & Dismemberment coverage for Employees:

- Additional Life Benefit Options: 7x annual earnings, rounded to the next higher multiple of \$10,000, if not already an exact multiple thereof; or \$750,000
- Additional AD&D Benefit Options: 7x annual earnings, rounded to the next higher multiple of \$10,000, if not already an exact multiple thereof; or \$750,000
- Non-medical Maximum: The lesser of 3x earnings or \$250,000
- All amounts are rounded to the next higher multiple of \$1,000, if not already an exact multiple thereof

Base Life Coverage for Dependents:

- Base Spouse Life Benefit Options: \$50,000
- Non-Medical Maximum: \$50,000
- Base Child Benefit Options for Live Birth to under age 19: \$10,000
- Base Child Benefit Limit(s): to age 19 or age 25 if a full-time student

Additional Life and Accidental Death & Dismemberment coverage for Dependents:

- Additional Spouse Life Benefit Options: Amounts in \$5,000 increments to an overall maximum of \$250,000 as applied for by you and approved by Unum
- Non-Medical Maximum for Spouse: \$50,000
- Additional Spouse AD&D Benefit Options: Amounts in \$5,000 increments to an overall maximum of \$250,000 as applied for by you and approved by Unum
- Additional Child Life Benefit Options: Live birth, but under age 19 - \$5,000 increments to an overall maximum of \$25,000 as applied for by you and approved by Unum

- Additional AD&D Child AD&D Benefit Options: Live birth, but under age 19 - \$5,000 increments to an overall maximum of \$25,000 as applied for by you and approved by Unum
- Dependent Child Age Limit(s): to age 19 or age 25 if a full-time student

*The Amount of Life Insurance for a dependent will not be more than 100% of the employee benefit. Employees must be covered in order to insure coverage for dependents.

AD&D Covered Losses and Benefits:

- Full Benefit for loss of:
 - o Life
 - o Both hands, both feet, or sight in both eyes
 - o One hand & one foot
 - o One hand or foot & one eye
 - o Speech and hearing
- Half Benefit for loss of:
 - o One hand or one foot
 - o Sight of one eye
 - o Speech or hearing
- Quarter Benefit for loss of:
 - o Thumb and index finger of the same hand

AD&D Educational Benefit: 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 6% of the employee's AD&D Benefit Amount OR \$6,000. The maximum benefit payment is 4 per lifetime. The maximum benefit amount is \$24,000. The maximum benefit period is 6 years from the date of the first benefit payment.

AD&D Repatriation Benefit: Unum will pay an additional AD&D benefit up to \$5,000 for the preparation and transportation of your remains if the death occurs at least 100 miles from your principal residence.

AD&D Seatbelt and Airbag Benefit: Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which results in death while properly wearing a seatbelt and protected by an airbag.

- Benefit Amount:
 - o Seatbelt: 10% of the full amount of your AD&D benefit. The maximum benefit is \$25,000.
 - o Airbag: 5% of the full amount of your AD&D benefit. The maximum benefit is \$5,000.

Portability: If your employment ends with or you retire from Andrews University 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.

Life Insurance Coverage Exclusions: 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.

AD&D Insurance Coverage Exclusions: AD&D benefits are excluded (not paid) for losses caused by, contributed to by, or resulting from:

- Self-destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane;
- Active participation in a riot
- An attempt to commit or commission of a crime
- The use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your or your dependent's physician. This exclusion will not apply to you or your dependent if the chemical substance is ethanol;
- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Being intoxicated;
- War, declared or undeclared, or any act of war.

Questions: If you should have any questions about your coverage or how to enroll, please contact the Andrews University Benefits Department.

Changes to Coverage: At each annual enrollment period or within 31 days of a change in status, you will be given the opportunity to change your coverage.

Delayed Effective Date of Coverage:

- Employee: Insurance coverage will be delayed if you are not in an active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective
- Dependent: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: Infants are insured from Live Birth.
- "Totally disabled" means that, as a result of an injury, sickness, or 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.

Long Term Disability provided through Unum

Eligibility: All eligible Full-Time Employees in the United States with the Employer.

Monthly Benefit Amount: The lesser of 66.67% of monthly earnings or a maximum monthly benefit of \$6,000. Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

Minimum Monthly Benefit: An amount equal to the greater of \$100 or 10% of your gross disability payment.

Elimination/Accumulation Periods: You must be continuously disabled through your elimination period. The days that you are not disabled will not count toward your elimination period. **Your elimination period is 90 days.** In addition, if you return to work while satisfying your elimination period and are no longer disabled, you may satisfy your elimination period within the accumulation period. You do not need to be continuously disabled through your elimination period if you are satisfying your elimination period under this provision. If you do not satisfy the elimination period within the accumulation period, a new period of disability will begin. **Your Accumulation period is 180 days.**

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 SSADEA (Social Security Normal Retirement Age) duration schedule.

Definition of Disability: Two Year Own Occupation with Residual

- You are disabled when Unum determines that you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury AND you have 20% or more loss in your indexed monthly earnings due to the same sickness or injury.
- After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training, or experience.
- You must be under the regular care of a physician in order to be considered disabled.

Survivor Benefit: When Unum receives proof that you have died, your eligible survivor will be paid a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death your disability had continued for 180 or more consecutive days AND you were receiving or were entitled to receive payments under the plan.

Rehabilitation and Return to Work Services: The rehabilitation program may include, but is not limited to, the following services and benefits:

- Coordination with your Employer to assist you to return to work;
- Adaptive equipment or job accommodations to allow you to work;
- Vocational evaluation to determine how your disability may impact your employment options;
- Job placement services;
- Resume preparation
- Job seeking skills training; or education and retraining expenses for a new occupation

Rehabilitation and Return to Work Benefits: We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of \$1,000 per month. This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- You are participating in the Rehabilitation and Return to Work Assistance program; and
- You are not able to find employment

Pre-Existing Conditions: You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three 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 three consecutive months after your effective date of coverage.

Mental Nervous and Self-Reported Symptoms Limitation: The lifetime cumulative maximum benefit period for all disabilities due to mental illness and self-reported symptoms is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities are not continuous and/or are not related. Payments would continue beyond 24 months if you are defined to a hospital or institution

Coverage Exclusions: Your plan does not cover any disabilities cause by, contributed to by, or resulting from:

- 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
- Disability due to war, declared or undeclared, or any act of war
- Period of disability of disability during which you are incarcerated.

Worldwide Travel Assistance provided through Unum

If you travel at least 100 miles from home, be sure to pack your emergency travel assistance information! Travel assistance speaks your language, helping you locate hospitals, embassies, and other unexpected travel destinations. One call connects you and your family to medical and other important services 24 hours a day. **Call: 1-800-872-1414 or 301-656-4152, reference #: 01-AA-UN-762490**

Use your travel assistance phone numbers 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 service
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

When 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.

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, travel assistance will provide support for all your medical needs.

Q: Who pays for the services I use? **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. 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.

Employee Assistance Program (EAP) provided through 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 www.unum.com/lifebalance 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 CA and NV, 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.

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.

Voluntary Short Term Disability provided through Unum

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 choose monthly benefit amounts and you can use it any way you choose. This plan is offered to all eligible employees ages 17 to 69 who are actively at work. You decide if its right for you and 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 and can keep it if you leave or retire. Unum will bill you directly for the same cost.
2. Coverage is effective on the first of the month that payroll deductions begin.
3. Your policy is guaranteed renewable until age 72 as long as you pay the premiums on time.
4. Premiums are based on your age on the policy effective date and are deducted from your paycheck.

Waiver of Premium: You don't have to pay your premiums after 90 days of total disability or the elimination period (whichever is longer). They'll be waived as long as the disability continues, up to the maximum benefit period.

Policy Provisions:

- **Pregnancy:** Nine months after coverage becomes effective, pregnancy is considered the same as any other covered illness. 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.

* Pre-existing condition: 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 pre-existing will be based on the date of disability and not the date you notify Unum.

My Short Term Disability Coverage (For your records)

Amount I applied for: \$ _____

Date deductions begin: ____/____/____

Cost per pay period: \$ _____

Voluntary Accident provided by Unum

Voluntary accident provides lump sum benefits for covered accidents that occur on or off the job. The plan is offered to all eligible employees who are actively at work, spouse ages 17-64 and children up to age 26.

Examples of covered injuries and expenses include:

- Broken bones
- Burns
- Torn ligaments
- Stitches
- Concussion
- Emergency Room treatment
- Outpatient surgery facility
- Physical Therapy
- Doctor's office visit

Four reasons to buy this coverage at work:

1. No health questions! If you apply, you automatically receive this base plan.
2. This plan is portable, so you may take the coverage with you if you leave or retire. Unum will bill you for the same cost
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.
4. Premiums are deducted from your paycheck.

The following benefits are automatically included in your plan:

- **Wellness Benefits:** 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 option - Sickness Hospital confinement benefit: This option pays the insured member 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.

Example: Claimant falls at home resulting in a torn ACL

- **Expenses incurred:** \$100 ER copay, \$500 deductible, \$700 surgery costs, \$150 PT copays
- **Benefits Paid:** \$150 ER visit, \$100 knee brace, \$800 surgical ligament repair, \$150 PT, \$75 follow-up appointment

My Accident Coverage (For your records)

Coverage Plan chosen: _____

Date deductions begin: ____/____/____

Cost per pay period: \$ _____

Voluntary Critical Illness provided through Unum

Critical illness insurance pays benefits at the diagnosis of a covered illness. If you receive a full benefit payout for a covered illness, 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.

Eligibility:

- **Employee:** Must be actively at work. Can purchase benefits in \$1,000 increments, from \$5,000 up to \$50,000
- **Spouse:** Age 17-64 and employee coverage must be selected. Can purchase benefits in \$1,000 increments from \$5,000 up to \$30,000
- **Dependent Children:** Up to age 26. Children are automatically covered at 25% of the employee benefit at no additional cost.

Three reasons to buy this coverage at work:

1. You get affordable rates. The premiums are then deducted from your paycheck.
2. Coverage is portable. You may take it with you if you leave or retire Unum will bill you directly for the same cost.
3. Benefits are effective the first of the month that payroll deductions begin

Examples of covered illnesses:

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

Additional illnesses covered for dependent children (diagnosis must occur after effective date):

- Cerebral Palsy
- Cystic Fibrosis
- Spinal Bifida
- Cleft Lip or Palate
- Downs Syndrome

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

The following is automatically included:

- **Wellness:** Based on the plan selected by your employer, this benefit can pay \$50 per calendar year per individual if a covered health screening is performed. If you have other policies with the wellness feature, you can receive a total of one benefit payment per year. A complete list of covered tests will be provided in your certificate.
- **Reduction of benefits:** The benefit amount for the employee and spouse reduces 50% on the first policy anniversary date after the insured's 70th birthday. Premiums will not be reduced. For coverage purchased after age 70, benefit amounts will not be reduced.

My Critical Illness Coverage *(For your records)*

Amount I applied for: \$ _____

Date deductions start: ____/____/____

Cost per pay period: \$ _____

Whole Life provided through Unum

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	
	Non-Tobacco User	Tobacco User
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

Sample Rates	Face amounts based on \$10 per week	
	Non-Tobacco User	Tobacco User
25	\$57,701	\$34,256
35	\$38,835	\$23,572
45	\$23,163	\$13,670
55	\$12,133	\$7,273
65	\$5,885	\$4,133

Alternative Treatment

Covered expenses under the Plan may be expanded in certain situations in to provide the most appropriate and cost-effective level of care. 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

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/injury. Eligible charges for transportation to and from the hospital or facility and charges for the diagnosis and treatment of an illness/injury shall be paid in the same manner as in-network medical benefits in terms of the Plan's requirements (deductible, coinsurance, etc.). The Plan's normal usual and customary fee limitations will not apply to these services.

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 their health plan ID 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 them locate a JCI-accredited hospital or facility that can perform the 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 services performed at the JCI-accredited hospital or facility, all related expenses may be ineligible under the Plan if the covered person proceeds to have the services performed at the JCI-accredited hospital or facility outside of the United States. See the Plan Document/SPD for additional information.

Traveling out of the Country

If a Participant receives treatment from an out-of-network provider while traveling out of the country, all eligible claims will be paid at the in-network level. The plan will provide coverage for medically necessary services, drugs, and supplies should you require urgent or emergency care. Most foreign providers will require that you pay for such services in full at the time of service. You must submit the receipt (translated into English if possible) to ASR or Navitus in order to receive reimbursement. You must contact ASR and explain that you received urgent or emergency care while traveling out of the US, and that you could not 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: the plan will not cover charges incurred outside of the US if the purpose of the travel is to obtain medical services, drugs, or supplies (except as covered under the Global Healthcare Benefit). The plan will not cover services, procedures, or treatment in a foreign country that are not normally covered under the terms of the plan.

Paid Leave Plan

This plan is available to **Hourly Employees** in classifications: HH, HF, HP.

The Purpose of this 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), 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 denomination employment. The leave bank illustrated below is based on a 40-hour work week.

Except for holidays and sick leave, the Paid Leave Bank (PLB) may be used at the discretion of the employee upon prior arrangement with the department head. Time in the PLB 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 PLB accrues only on the first 80 hours of paid time in a two-week pay period.

Years of Service	Total Hours	Equivalent Days	Maximum Annual Accrual	Hourly Rate of Accrual
1 through 4	0 – 7,488	25	200 hours	0.0961538
5 through 9	7,489 – 16,848	30	240 hours	0.1153846
Starting 10 th year	Begin 16,849	35	280 hours	0.1346153

Andrews University recognizes eight holidays, two of which are 1.5 days, for a total of nine days annually. The holidays are as follows:

- New Year's Day
- Martin Luther King Jr. Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving (1.5)
- Christmas (1.5)

Vacation Plan

This plan is available to **Salary/Faculty Employees** in classifications: AF, AP, SA, SF, SP, FA, FF, FT, FP.

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 on fifth of your vacation week.

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 the Employees' Spouse: The spouse of a staff member (class AF, SA, SF, FA, FF, or FT) may receive assistance through the master's level degree program. 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.

Tuition Assistance

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 (age requirement exceptions may be made 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 the student is residing in a school dormitory or not. 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 (including summer semesters) of undergraduate or graduate study; graduate study must occur at Andrews University. The number of semesters eligible for assistance is prorated, based on prior university enrollment, when eligibility begins.

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.

Defined Contribution Retirement Plan

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:

- www.empowermyarp.com, providing secure 24-hour online access to your account and investment information
- Call 855-756-4738 to speak with a Participant Services Representative between 6:00 AM and 8:00 PM MT, Monday through Friday
- A quarterly statement will be sent to keep you up to date on your portfolio's progress

Please carefully read 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.

Counselors: Suzanne McHugh and Brian Hand

Email: suzanne.mchugh@empower-retirement.com and brian.hand@empower-retirement.com

Phone: Suzanne: 240.224.4911. Brian: 720.701.2039

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 APR'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.

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Andrews  University
Seek Knowledge. Affirm Faith. Change the World.