Andrews University, G-773

Benefit Description	Premier Plan		Standard Plan		High Deductible Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefit Year	July 1 through June 30		July 1 through June 30		July 1 through June 30	
Comprehensive Medical Benefit 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.	

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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
Outpatient Physician Services (Includes Office Visits, Telemedicine E-Visits, and Second Surgical Opinions) Physician's Fee for an Examination	*Telemedicine E-Visits:* $0 copayment per visit, then 100% (deductible waived) *Other Office Visits:* $20 co-payment per visit, then 100% (deductible waived)	*Telemedicine E-Visits:* 60% after deductible *Other Office Visits:* 60% after deductible	*Telemedicine E-Visits:* $0 copayment per visit, then 100% (deductible waived) *Other Office Visits:* $30 co-payment per visit, then 100% (deductible waived)	*Telemedicine E-Visits:* 60% after deductible *Other Office Visits:* 60% after deductible	*Telemedicine E-Visits:* 80% after deductible *Other Office Visits:* 80% after deductible	*Telemedicine E-Visits:* 60% after deductible *Other Office Visits:* 60% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered
Routine Preventive Care Physician's Fee for an Examination Routine X-Rays and Lab Tests Flu Shots and Other Routine Immunizations FDA-Approved Contraceptive Methods and Sterilization Procedures for Women with Reproductive Capacity Mammograms, Colonoscopies, and Other Routine Services	100%; deductible waived	Not covered	100%; deductible waived	Not covered	100%; deductible waived	Not covered
Urgent Care Center Visits Physician's Fee for an Examination	$75 co-payment per visit, then 100% (deductible waived)	60% after deductible	$75 co-payment per visit, then 100% (deductible waived)	60% after deductible	80% after deductible	60% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered
Emergency Room Treatment Hospital's Fee for the Use of the Emergency Room	$250 co-payment* per visit, then 100% (deductible waived) *may waive if admitted	Paid as in-network	$250 co-payment* per visit, then 100% (deductible waived) *may waive if admitted	Paid as in-network	80% after deductible	Paid as in-network

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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
Chiropractic Care						
Spinal Manipulations, Therapy Treatments, and a Physician's Fee for an Initial or Periodic Evaluation	$20 co-payment per day, then 100% (deductible waived)	$20 co-payment per day, then 100% (deductible waived)	$30 co-payment per day, then 100% (deductible waived)	$30 co-payment per day, then 100% (deductible waived)	80% after deductible	Paid as in-network
Diagnostic Spinal X-Rays	90% after deductible	Paid as in-network	80% after deductible	Paid as in-network	80% after deductible	Paid as in-network
$500 Maximum Paid per Covered Person per Benefit Year for All Chiropractic Care and Massage Therapy Combined (In-Network and Out-of-Network Services Combined)						
Massage Therapy (Medically Necessary Services Only) $500 Maximum Paid per Covered Person per Benefit Year for All Chiropractic Care and Massage Therapy Combined (In-Network and Out-of-Network Services Combined)	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Outpatient Rehabilitative Services Physical Therapy, Speech Therapy, and Occupational Therapy	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment, Prosthetics, and Orthotics	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hearing Services						
Hearing Exams	$20 co-payment per visit, then 100% (deductible waived)	Not covered	$30 co-payment per visit, then 100% (deductible waived)	Not covered	80% after deductible	Not covered
Hearing Testing	90% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	Not covered
Hearing Aids	75% after deductible	Paid as in-network	75% after deductible	Paid as in-network	75% after deductible	Paid as in-network
$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)						
Special Note about Hearing Services Benefit: Hearing screening tests of a newborn are covered under the Routine Preventive Care benefit						
Behavioral Care (Includes Mental Health Care and Addictions Treatment) Inpatient/Partial Hospitalization Services Outpatient/Intensive Outpatient Services, including Telemedicine E-Visits	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Infertility Treatment $3,000 Lifetime Maximum Paid per Covered Person for All Eligible Infertility Treatment (In-Network Services Only)	60% after deductible	Not covered	60% after deductible	Not covered	60% after deductible	Not covered
Special Note about Infertility Treatment: Eligible prescription drugs prescribed for the treatment of infertility are not covered under this benefit, but may be eligible for coverage under the Plan's Prescription Drug benefit.						
Convalescent Care and Home Health Care	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospice	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible

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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.

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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	
	Drug Category 1 Co-payments: Drugs Costing Less than $400	**Drug Category 2 Co-payments: Drugs Costing $400 or More**
Prescription Drugs	Retail Prescription Drug Co-Payments (30-Day Supply) $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 Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply 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. Mail Order Prescription Drug Co-Payments (90-Day Supply) $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 Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply	If a Prescription Drug Assistance Program is Not Available Subject to the applicable co-payment specified in Drug Category 1 (see other column) If a Prescription Drug Assistance Program is Available Up to 50% of the drug's purchase price* *Generally, a covered person will realize a $0 out-of-pocket expense by utilizing a Prescription Drug Assistance Program to purchase a program-eligible drug, as identified and determined by Health Plan Advocate. Contact Health Plan Advocate at (866) 680-4859 ext. 206 for assistance in determining if a Prescription Drug Assistance Program is available. The Plan will continue to assess this co-payment until any amounts available under a Prescription Drug Assistance Program have been exhausted. However, the amount that a covered person pays out of pocket for covered expenses in a Benefit Year will not exceed the Plan's Prescription Drug Maximum Out-of-Pocket.

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Benefit Description	Premier Plan Prescription Drug Benefit Description
Prescription Drug Maximum Out-of-Pocket per Benefit Year	$2,800/person* $5,600/family*

*The Prescription Drug Maximum Out-of-Pocket includes prescription drug co-payment amounts paid for eligible purchases made through the Prescription Drug Card Program, the Mail Service Program, or the Specialty Pharmacy Program. The Prescription Drug Maximum Out-of-Pocket 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.

Special Notes about Prescription Drug Coverage:

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. As used in this benefit, the term Prescription Drug Assistance Program includes, but is not limited to, the following: manufacturer co-payment assistance programs, non-profit foundation co-payment assistance grants, manufacturer free drug programs, disease-based healthcare grants, government-sponsored programs, and prescription savings clubs, including organizations such as Amazon, GoodRx, etc.
3. 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.
4. 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.
5. 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.
6. 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.
7. Prescription drugs that are not on the formulary drug list maintained by the PBM are not eligible for coverage under the Plan. If a covered person is using an excluded medication under the PBM's formulary list, he or she should speak to a physician to determine if there is an alternative therapy that provides the same therapeutic efficacy. Covered persons can contact the PBM using the phone number on the front of their identification cards for additional information about the coverage status of a particular drug.
8. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan at 100% (no co-payment will be applied). The covered persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.
9. 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.
10. 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 may be required to provide additional information, and failure to participate may result in the full cost of the drug being the covered person's responsibility (these costs will still apply toward the Prescription Drug Maximum Out-of-Pocket). 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. Costs paid by drug manufacturer assistance programs, disease-specific society assistance programs, and public assistance programs will not apply toward the In-Network Medical Total Maximum Out-of-Pocket or the Prescription Drug Maximum Out-of-Pocket.
11. 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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Benefit Description	Standard Plan Prescription Drug Benefit Description	
Prescription Drugs	**Drug Category 1 Co-payments: Drugs Costing Less than $400**	**Drug Category 2 Co-payments: Drugs Costing $400 or More**
	Retail Prescription Drug Co-Payments (30-Day Supply) $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 Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply 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. Mail Order Prescription Drug Co-Payments (90-Day Supply) $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 Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply	If a Prescription Drug Assistance Program is Not Available Subject to the applicable co-payment specified in Drug Category 1 (see other column) If a Prescription Drug Assistance Program is Available Up to 50% of the drug's purchase price* *Generally, a covered person will realize a $0 out-of-pocket expense by utilizing a Prescription Drug Assistance Program to purchase a program-eligible drug, as identified and determined by Health Plan Advocate. Contact Health Plan Advocate at (866) 680-4859 ext. 206 for assistance in determining if a Prescription Drug Assistance Program is available. The Plan will continue to assess this co-payment until any amounts available under a Prescription Drug Assistance Program have been exhausted. However, the amount that a covered person pays out of pocket for covered expenses in a Benefit Year will not exceed the Plan's Prescription Drug Maximum Out-of-Pocket.
Prescription Drug Maximum Out-of-Pocket per Benefit Year	$1,800/person* $3,600/family*	

*The Prescription Drug Maximum Out-of-Pocket includes prescription drug co-payment amounts paid for eligible purchases made through the Prescription Drug Card Program, the Mail Service Program, or the Specialty Pharmacy Program. The Prescription Drug Maximum Out-of-Pocket 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.

Special Notes about Prescription Drug Coverage:

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. As used in this benefit, the term Prescription Drug Assistance Program includes, but is not limited to, the following: manufacturer co-payment assistance programs, non-profit foundation co-payment assistance grants, manufacturer free drug programs, disease-based healthcare grants, government-sponsored programs, and prescription savings clubs, including organizations such as Amazon, GoodRx, etc.
3. 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.
4. 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.
5. 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.
6. 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.
7. Prescription drugs that are not on the formulary drug list maintained by the PBM are not eligible for coverage under the Plan. If a covered person is using an excluded medication under the PBM's formulary list, he or she should speak to a physician to determine if there is an alternative therapy that provides the same therapeutic efficacy. Covered persons can contact the PBM using the phone number on the front of their identification cards for additional information about the coverage status of a particular drug.
8. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan at 100% (no co-payment will be applied). The covered persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.

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Benefit Description	Standard Plan Prescription Drug Benefit Description

Special Notes about Prescription Drug Coverage:

9. 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.

10. 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 may be required to provide additional information, and failure to participate may result in the full cost of the drug being the covered person's responsibility (these costs will still apply toward the Prescription Drug Maximum Out-of-Pocket). 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. Costs paid by drug manufacturer assistance programs, disease-specific society assistance programs, and public assistance programs will not apply toward the In-Network Medical Total Maximum Out-of-Pocket or the Prescription Drug Maximum Out-of-Pocket.

11. 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	
Prescription Drugs Covered Preventive Drugs Purchased Before the In-Network Deductible is Satisfied	The applicable co-payments and day-supply limits described below apply to each purchase (no deductible applies). The co-payment charged will depend on the type of medication, the drug's classification by the PBM, and the dosage. 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.	
Covered Non-Preventive Drugs Purchased Before the In-Network Deductible is Satisfied	The covered person must pay the full cost of the prescription at the time of purchase. The amount paid to purchase an eligible prescription drug will apply toward the in-network deductible. If an eligible prescription drug is purchased at a pharmacy within the appropriate network, through the Mail Service Program, or from the Lumicera Health Services specialty pharmacy, the covered person may receive a discount toward the purchase price of the drug. The availability and amount of the discount will depend on the type of medication, the drug's classification by the PBM, and the dosage.	
Eligible Drugs Purchased After the In-Network Deductible is Satisfied	**Drug Category 1 Co-payments: Drugs Costing Less than $400**	**Drug Category 2 Co-payments: Drugs Costing $400 or More**
Retail (90-Day Supply), Mail (90-Day Supply), Specialty Pharmacy (30-Day Supply)	20% of the purchase price/Formulary prescription drug Specialty Prescription Drugs are eligible; contact the PBM to learn the co-payment that will be charged and other special terms that may apply	If a Prescription Drug Assistance Program is Not Available Subject to the applicable co-payment specified in Drug Category 1 (see other column) If a Prescription Drug Assistance Program is Available Up to 50% of the drug's purchase price* *Generally, a covered person will realize a $0 out-of-pocket expense by utilizing a Prescription Drug Assistance Program to purchase a program-eligible drug, as identified and determined by Health Plan Advocate. Contact Health Plan Advocate at (866) 680-4859 ext. 206 for assistance in determining if a Prescription Drug Assistance Program is available. The Plan will continue to assess this co-payment until any amounts available under a Prescription Drug Assistance Program have been exhausted. However, the amount that a covered person pays out of pocket for covered expenses in a Benefit Year will not exceed the Plan's In-Network Total Maximum Out-of-Pocket.

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Benefit Description	High Deductible Health Plan Prescription Drug Benefit
Prescription Drugs, cont.	
Drugs Purchased After the In-Network Total Maximum Out-of-Pocket is Satisfied	Plan pays 100% of the drug's purchase price; no co-payment applies

Special Notes about Prescription Drug Coverage:

1. As used in this benefit, the term Prescription Drug Assistance Program includes, but is not limited to, the following: manufacturer co-payment assistance programs, non-profit foundation co-payment assistance grants, manufacturer free drug programs, disease-based healthcare grants, government-sponsored programs, and prescription savings clubs, including organizations such as Amazon, GoodRx, etc.
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 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
4. 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.
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 Pharmacy Benefits Manager (PBM) using the information listed on the front of his/her identification card.
6. Prescription drugs that are not on the formulary drug list maintained by the PBM are not eligible for coverage under the Plan. If a covered person is using an excluded medication under the PBM's formulary list, he or she should speak to a physician to determine if there is an alternative therapy that provides the same therapeutic efficacy. Covered persons can contact the PBM using the phone number on the front of their identification cards for additional information about the coverage status of a particular drug.
7. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan at 100% (no co-payment or deductible will be applied). The covered persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.
8. Covered prescription drugs obtained at a retail pharmacy must be filled at an eligible retail network pharmacy or else the drug purchase will not be eligible for coverage under the Plan. For additional details, reference the important note about retail network pharmacies in this summary. The covered person can also contact the PBM using the information listed on the front of his/her identification card for assistance with finding an eligible retail network pharmacy.
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 may be required to provide additional information, and failure to participate may result in the full cost of the drug being the covered person's responsibility (these costs will still apply toward the In-Network Total Maximum Out-of-Pocket). Covered persons prescribed a Specialty Prescription Drug should contact the PBM listed on the front of his/her 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. Costs paid by drug manufacturer assistance programs, disease-specific society assistance programs, and public assistance programs will not apply toward the In-Network Total Maximum Out-of-Pocket.
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.

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.	
Benefit Percentage	
Type I - Preventive Dental Services	100%; deductible waived (0% coinsurance)
Type II - Minor Restorative Dental Services	75% after deductible (25% coinsurance)
Type III - Major Restorative Dental Services	75% after deductible (25% coinsurance)
Type IV - Orthodontic Services (for dependent children under age 24 only)	50% after deductible (50% coinsurance)

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Benefit Description	Dental Plan
	Limits (In-Network and Out-of-Network)
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.
Vision Supply Expenses	
Eyeglass Frames	100% (0% coinsurance)
Eyeglass Lenses, Including Eyeglass Lens Add-Ons Such As Tinting, Ultraviolet Coatings, Scratch-Resistant Coatings, and Anti-Reflective Coatings	100% (0% coinsurance)
Contact Lenses	100% (0% coinsurance)
Maximum Benefit Paid per Covered Person per Benefit Year for All Eligible Vision Supply Expenses	$250

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