



UNIVERSITY OF NOTRE DAME

MEDICAL/DENTAL/VISION

PLAN SUMMARY 2009

MEDICAL/DENTAL/VISION PLAN SUMMARY - 2009

To help you make informed decisions about your insurance election, the University has prepared this 2009 Medical/Dental/Vision Plan Summary. This summary is intended to help you learn more about the benefit plans available to you. It does not replace the legal plan documents or contracts for each of the benefit plans and should not, in any way, be considered a legal contract or guarantee of coverage.

You are responsible for notifying the Office of Human Resources within 31 days of a qualifying life event, such as marriage, childbirth, adoption, and loss or gain of other insurance coverage. **(If you do not apply for additional coverage due to a status change within 31 days of the event, you may not make the change until the next Open Enrollment Period.)**

IMPORTANT CONTACT INFORMATION

Medical	Meritain Select HMO: Member Service	www.meritain.com	1-888-668-6855
	<ul style="list-style-type: none"> Eligibility, benefit coverage, pre-certification, claim questions 	www.selecthealthnetwork.com	1-888-668-6855
	<ul style="list-style-type: none"> Select Health Network (Local Network) 	www.newavenuesonline.com	1-800-223-6246
	<ul style="list-style-type: none"> New Avenues Midwest Behavioral Health Network (mental health provider) Lakeland Network (Southwest MI) 	www.lakelandcare.com	1-269-927-5207
	Meritain PPO:	www.meritain.com	1-888-668-6855
	<ul style="list-style-type: none"> Eligibility, benefit coverage, pre-certification, claim questions 	www.selecthealthnetwork.com	1-888-668-6855
	<ul style="list-style-type: none"> Select Health Network (Local Network) Beech Street (National Network) 	www.beechstreet.com	1-800-432-1776
	<ul style="list-style-type: none"> New Avenues Midwest Behavioral Health Network (mental health provider) Lakeland Network (Southwest MI) 	www.newavenuesonline.com	1-800-223-6246
		www.lakelandcare.com	1-269-927-5207
	Meritain CHA HMO:	www.meritain.com	1-888-668-6855
	<ul style="list-style-type: none"> Eligibility, benefit coverage, pre-certification, claim questions 	www.chanetwork.com	1-888-689-2242 or 1-574-284-1820
	<ul style="list-style-type: none"> Community Health Alliance (CHA) Network Lakeland Network (Southwest MI) 	www.lakelandcare.com	1-269-927-5207
Prescription	Medco <ul style="list-style-type: none"> Benefit coverage, claim questions 	www.medco.com	1-800-711-0917
Dental	Delta Premier PPO	www.deltadental.com www.consumertoolkit.com	1-800-524-0149
	Delta Preferred PPO POS	www.deltadental.com www.consumertoolkit.com	1-888-455-5141
Vision	EyeMed	www.evemedvisioncare.com www.enrollwiththeyemed.com	1-866-939-3633

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO																					
<p>General Information</p>	<p>Under Meritain PPO, you must call Meritain at the toll-free number, 1-888-668-6855 (on the back of your ID card) before you or a covered family member is admitted to the hospital. Your admission and length of your hospital stay will be reviewed, and if approved, you'll receive benefits based on whether you receive care from a network provider or non-network provider. Lists of Network physicians and hospitals are available at www.selecthealthnetwork.com (Local Network) or www.beechstreet.com (National Network). In the case of a life-threatening emergency, notification to the toll-free number, 1-888-668-6855, must be initiated within 48 hours or the first business day following hospital admission. If a call is not made, a reduced benefit may be paid.</p>	<p>Services are provided by physicians associated with the HMO. To be eligible, a person (and dependents) must reside or work in the HMO's service area. The Health Plan does not require a referral for Specialist Care within the network. Lists of Network physicians and hospitals are available at www.selecthealthnetwork.com or by calling 1-888-668-6855.</p> <p>Benefit coverage listed pertains to In-Network providers only.</p>	<p>Services are provided by physicians associated with the HMO. To be eligible, a person (and dependents) must reside or work in the HMO's service area. The Health Plan does not require a referral for Specialist Care within the network. Lists of Network physicians and hospitals are available at www.chanetwork.com or by calling (574) 284-1820 or 1-888-689-2242.</p> <p>Benefit coverage listed pertains to In-Network providers only.</p>																					
<p>Monthly Premiums <i>(full-time Faculty, Administrators and Staff)</i></p>	<table border="0"> <tr> <td>Individual</td> <td>\$ 54.00</td> </tr> <tr> <td>Individual + 1</td> <td>\$ 190.00</td> </tr> <tr> <td>Family</td> <td>\$ 217.00</td> </tr> </table>	Individual	\$ 54.00	Individual + 1	\$ 190.00	Family	\$ 217.00	<table border="0"> <tr> <td>Individual</td> <td>\$ 35.00</td> </tr> <tr> <td>Individual + 1</td> <td>\$ 120.00</td> </tr> <tr> <td>Family</td> <td>\$ 140.00</td> </tr> </table>	Individual	\$ 35.00	Individual + 1	\$ 120.00	Family	\$ 140.00	<table border="0"> <tr> <td>Individual</td> <td>\$ 48.00</td> </tr> <tr> <td>Individual + 1</td> <td>\$ 180.00</td> </tr> <tr> <td>Family</td> <td>\$ 198.00</td> </tr> </table>	Individual	\$ 48.00	Individual + 1	\$ 180.00	Family	\$ 198.00			
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PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO																					
<p>Out-of-pocket limits Includes the annual deductible. (Note: Once the out-of-pocket limit is met on an annual basis, the plan pays 100% of eligible charges. No one family member may meet this limit for the whole family.)</p>	<table border="0"> <tr> <td></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td><u>In-Network</u></td> <td style="text-align: center;">\$1,250</td> <td style="text-align: center;">\$3,000</td> </tr> <tr> <td><u>Out-of-Network</u></td> <td style="text-align: center;">\$2,500</td> <td style="text-align: center;">\$5,000</td> </tr> </table>		<u>Individual</u>	<u>Family</u>	<u>In-Network</u>	\$1,250	\$3,000	<u>Out-of-Network</u>	\$2,500	\$5,000	<p><u>For In-patient Hospital Services Only</u></p> <table border="0"> <tr> <td></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td><u>In-Network</u></td> <td style="text-align: center;">\$800</td> <td style="text-align: center;">\$1,600</td> </tr> </table>		<u>Individual</u>	<u>Family</u>	<u>In-Network</u>	\$800	\$1,600	<p><u>For In-patient Hospital Services Only</u></p> <table border="0"> <tr> <td></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td><u>In-Network</u></td> <td style="text-align: center;">\$800</td> <td style="text-align: center;">\$1,600</td> </tr> </table>		<u>Individual</u>	<u>Family</u>	<u>In-Network</u>	\$800	\$1,600
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<p>Physician Office Visits (Co-payments)</p>	<p><u>In-Network:</u> \$20 physician co-payment per office visit (after the co-payment is made, the plan pays 100%). This \$20.00 co-payment is still required even after deductible is met.</p> <p><u>Out-of-Network:</u> Subject to annual deductible. After you meet your annual deductible, the plan pays 65% of eligible, reasonable, and customary charges and you pay the remaining 35% plus any amounts above reasonable & customary.</p>	<p><u>Primary Care Physician – In-Network</u> 100% after \$20 co-payment per primary care physician office visit. (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.)</p> <p><u>Specialist Physician – In-Network</u> 100% after \$30 co-payment per specialist physician office visit within the network.</p>	<p><u>Primary Care Physician – In-Network</u> 100% after \$20 co-payment per primary care physician office visit. (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.)</p> <p><u>Specialist Physician – In-Network</u> 100% after \$30 co-payment per specialist physician office visit within the network.</p>																					
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Allergy Testing	<u>In-Network:</u> 85% <u>Out-of-Network:</u> 65% After annual deductible is met.	100% after \$30 co-payment per specialist physician office visit.	100% after \$30 co-payment per specialist physician office visit.
Allergy Treatment	<u>In-Network:</u> \$20 co-pay <u>Out-of-Network:</u> 65% after deductible	\$20 co-pay PCP 100% after \$30 co-payment per specialist physician office visit.	\$20 co-pay PCP 100% after \$30 co-payment per specialist physician office visit.
Ambulance	85% after deductible	No charge for service (from area first disabled) to nearest facility qualified to provide care when medically necessary and approved by the Plan.	No charge for service (from area first disabled) to nearest facility qualified to provide care when medically necessary and approved by the Plan.
Anesthesiology, Cardiac and Intensive Care	<u>In-Network:</u> 85% <u>Out-of-Network:</u> 65% After annual deductible is met.	<u>For In-patient Hospital Services Only</u> <u>In-Network:</u> 85% After annual deductible is met.	<u>For In-patient Hospital Services Only</u> <u>In-Network:</u> 85% After annual deductible is met.
Cardiac Rehabilitation	<u>In-Network:</u> 85% <u>Out-of-Network:</u> 65% After annual deductible is met.	\$30 specialist co-payment per office visit. 36 visits per year	\$30 specialist co-payment per office visit. 36 visits per year.
Children Eligibility <i>(Due to age)</i>	Children are eligible until they reach age 19 and are dependent on employee for at least 50% of financial support. If the children are full-time students (at least 12 credit hours) and unmarried, they remain covered until they reach age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.	Children are eligible until they reach age 19 and are dependent on employee for at least 50% of financial support. If the children are full-time students (at least 12 credit hours) and unmarried, they may remain covered until they reach age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.	Children are eligible until they reach age 19 and are dependent on employee for at least 50% of financial support. If the children are full-time students (at least 12 credit hours) and unmarried, they may remain covered until they reach age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.
Chiropractic Care	<u>In-Network:</u> \$20 co-pay <u>Out of Network:</u> 65% after deductible	\$20 co-pay (20 annual visits) See HR website for listing of covered chiropractors.	\$20 co-pay (20 annual visits) See HR website for listing of covered chiropractors.

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p>Coordination of Benefits (C.O.B.)</p>	<p>Meritain is primary for you (the employee), and your spouse’s employer’s insurance plan is primary for him or her. The two plans “coordinate” benefits for your dependent children. The “birthday rule” determines which plan is primary (pays first) for your dependent children. For example, if the month of your birthday falls <u>before</u> your spouse’s birthday month, Meritain will be primary and pay benefits first for your dependents.</p> <p>There are very specific rules about how insurance plans coordinate in situations such as legal separation or divorce. In these situations, the Office of Human Resources should be contacted.</p>	<p>Meritain is primary for you (the employee), and your spouse’s employer’s insurance plan is always primary for him or her. The two plans “coordinate” benefits for your dependent children. The “birthday rule” determines which plan is primary (pays first) for your dependent children. For example, if the month of your birthday falls <u>before</u> your spouse’s birthday month, Meritain will be primary and pay benefits first for your dependents.</p> <p>If another plan is primary, Meritain will consider the remaining eligible charges. Meritain would coordinate for any service within their network.</p>	<p>Meritain is primary for you (the employee), and your spouse’s employer’s insurance plan is primary for him or her. The two plans “coordinate” benefits for your dependent children. The “birthday rule” determines which plan is primary (pays first) for your dependent children. For example, if the month of your birthday falls <u>before</u> your spouse’s birthday month, Meritain will be primary and pay benefits first for your dependents.</p> <p>If another plan is primary, Meritain will consider the remaining eligible charges. Meritain would coordinate for any service within their network.</p>
<p>Diabetic Supplies Part of the Pharmacy Benefit.</p>	<p>Not Applicable</p>	<p>Not Applicable</p>	<p>Not Applicable</p>
<p>Durable Medical Equipment</p>	<p><u>In-Network</u> After deductible, plan pays 85% of eligible charges up to annual maximum.</p> <p><u>Out-of-Network</u> After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges up to the annual maximum.</p> <p>Annual maximum of \$15,000 per person / per year.</p>	<p>Covered in full with prior approval from Meritain Health.</p>	<p>Covered in full with prior approval from Meritain Health.</p>
PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO

Emergency Services <i>(Out-of-Area/Out-of-State)</i>	<p>You are not required to contact Meritain before seeking medical treatment. If a network provider is used, benefits are paid at 85% after deductible. If an out-of-network provider is used, benefits are paid at 65% of U&C (usual and customary) after deductible. If you are out of the area at the time emergency treatment is required, and it is not life threatening, you may call Beech Street at 1-800-432-1776 to locate the nearest national network provider. If the medical emergency turns into an inpatient hospital admission, the physician or the employee should contact Meritain within 48 hours to have the stay pre-certified.</p>	<p>If you have a medical emergency and your medical condition is dangerous or life threatening, you should go to the nearest medical facility for treatment (whether you are in the service area or out of the area).</p> <p>Contact Meritain Health to notify them of the emergency treatment.</p> <p>\$120 co-payment for Emergency Room</p> <p>Routine medical care and non-emergency care received out of town is not covered.</p>	<p>If you have a medical emergency and your medical condition is dangerous or life threatening, you should go to the nearest medical facility for treatment (whether you are in the service area or out of the area).</p> <p>Contact Meritain Health to notify them of the emergency treatment.</p> <p>\$120 co-payment for Emergency Room</p> <p>Routine medical care and non-emergency care received out of town is not covered.</p>
Emergency Services <i>(In-Area)</i>	<p><u>Network:</u> 85%</p> <p><u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met.</p> <p><u>Urgent Care</u> \$50 co-payment for services provided at Urgent Care Center.</p>	<p>\$120 co-payment for Emergency Room (waived if patient is admitted).</p> <p><u>Urgent Care</u> \$40 co-payment for services provided at Urgent Care Center.</p>	<p>\$120 co-payment for Emergency Room (waived if patient is admitted).</p> <p><u>Urgent Care</u> \$40 co-payment for Urgent Care Facility at MedPoint and other CHA Urgent Care providers. \$25 co-pay for urgent care at Medpoint Express.</p>
Fertility Testing and Counseling	<p><u>Network:</u> 85%</p> <p><u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met.</p> <p>Provides coverage for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.</p>	<p>Provides coverage for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.</p>	<p>Provides coverage for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.</p>
PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
Genetic Testing	Not Covered	Not Covered	Not Covered
Hearing Aid Benefit	<u>Network:</u> 85%		

	<p><u>Out-of-Network:</u> 65%</p> <p>After the deductible and coinsurance have been applied/met. The plan will pay \$1500 of the reasonable and customary charges for fittings, approved hearing correction devices and the first set of batteries for hearing aids ever 36 months. All services must be provided by an audiologist or certified hearing aid specialist and recommended or prescribed by a physician. The Plan will not pay for the over-the-counter hearing aids, repair of broken, lost aids, or for the replacement batteries.</p>	<p>The plan will pay 100% up to \$1500 of the reasonable and customary charges for fittings, approved hearing correction devices and the first set of batteries for hearing aids every 36 months. All services must be provided by an audiologist or certified hearing aid specialist and recommended or prescribed by a physician within the network. The Plan will not pay for over-the-counter hearing aids, repair of broken, lost aids or for replacement of batteries.</p>	<p>The plan will pay 100% up to \$1500 of the reasonable and customary charges for fittings, approved hearing correction devices and the first set of batteries for hearing aids every 36 months. All services must be provided by an audiologist or certified hearing aid specialist and recommended or prescribed by a physician within the network. The Plan will not pay for over-the-counter hearing aids, repair of broken, lost aids or for replacement of batteries.</p>
<p>Home Health Care</p>	<p><u>Network:</u> 85%</p> <p><u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met and if determined to be medically necessary. Subject to \$25,000 annual maximum/\$50,000 lifetime maximum. There may be some limitations.</p>	<p>100% after \$20 co-payment per visit. Limit of 60 visits per Calendar Year.</p>	<p>100% after \$20 co-payment per visit. Limit of 60 visits per Calendar Year.</p>
<p>Hospital Room & Board</p>	<p><u>Network:</u> 85%</p> <p><u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met.</p>	<p>After your meet your annual deductible, the plan pays 85% of eligible charges and you pay the remaining 15%.</p>	<p>After your meet your annual deductible, the plan pays 85% of eligible charges and you pay the remaining 15%.</p>
<p>Human Organ Transplants</p>	<p>Meritain utilizes Life Trac as their program for transplants and other services. Life Trac program offers over 30 hospitals across the US including, Chicago Medical Center, University of Michigan Medical Center, Memorial Sloan-Kettering Cancer Center, and MD Anderson.</p>	<p>Meritain utilizes Life Trac as their program for transplants and other services. Life Trac program offers over 30 hospitals across the US including, Chicago Medical Center, University of Michigan Medical Center, Memorial Sloan-Kettering Cancer Center, and MD Anderson.</p>	<p>Meritain utilizes Life Trac as their program for transplants and other services. Life Trac program offers over 30 hospitals across the US including, Chicago Medical Center, University of Michigan Medical Center, Memorial Sloan-Kettering Cancer Center, and MD Anderson.</p>

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<p>Hospitals</p>	<ul style="list-style-type: none"> • St. Joseph Community Hospital, Mishawaka, IN; • St. Joseph Regional Medical Center, Plymouth, IN; • St. Joseph’s Regional Medical Center, South Bend, IN; • Memorial Hospital Mother and Child Care Center and neo-natal nursery are included as in-network services. • Community Hospital of Bremen, Bremen, IN • Goshen General Hospital, Goshen, IN • Indiana University Medical Center, Indianapolis, IN • Lakeland Regional Medical Center, Niles, MI • La Porte Hospital, La Porte, IN • Methodist Hospital, Indianapolis, IN • Riley Children’s Hospital, Indianapolis, IN • Saint Anthony Hospital, Michigan City, IN • South Haven Community Hospital, South Haven, MI • University of Chicago, Chicago, IL • Cleveland Clinic, Cleveland, OH • Mayo Clinic, Rochester, MN <p>(See directory or web page for a complete listing.)</p>	<ul style="list-style-type: none"> • St. Joseph Community Hospital, Mishawaka, IN; • St. Joseph Regional Medical Center, Plymouth, IN; • St. Joseph’s Regional Medical Center, South Bend, IN; • Community Hospital of Bremen, Bremen, IN • Goshen General Hospital, Goshen, IN • Indiana University Medical Center, Indianapolis, IN • Lakeland Regional Medical Center, Niles, MI • La Porte Hospital, La Porte, IN • Methodist Hospital, Indianapolis, IN • Riley Children’s Hospital, Indianapolis, IN • Saint Anthony Hospital, Michigan City, IN • South Haven Community Hospital, South Haven, MI • University of Chicago, Chicago, IL <p>(See directory or web page for a complete listing.)</p>	<ul style="list-style-type: none"> • Memorial Hospital, South Bend, IN; • Adams County Memorial Hospital, Decatur, IN; • Bloomington Hospital; Bloomington, IN; • Clarian/I.U. Medical Center, Indianapolis, IN; • Clarian/Riley Hospital for Children, Indianapolis, IN; • Community Hospital of Bremen, Bremen, IN; • Elkhart General Hospital, Elkhart, IN; • LaPorte Hospital, LaPorte, IN; • Madison Hospital, South Bend, IN 46617; • Lakeland Medical Center-Niles, Niles, MI; • Oaklawn Psychiatric Center, Inc., Goshen, IN; • St. Anthony Memorial Health Center, Michigan City, IN; • University of Chicago Hospitals, Chicago, IL; • Cleveland Clinic, Cleveland, OH • Mayo Clinic, Rochester, MN <p>(See directory or web page for a complete listing.)</p>
<p>Laboratory/X-Ray Services (Billed by a radiologist, pathologist or hospital)</p> <p>*If performed in conjunction with office visit, the services are covered under the office visit benefit.</p>	<p><u>Network:</u> 85%</p> <p><u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met.</p>	<p><u>For In-patient Hospital Services Only</u></p> <p><u>In-Network:</u> 85%</p> <p>After annual deductible is met.</p> <p><u>For Out-patient Services</u></p> <p>Eligible charges are covered at 100%</p>	<p><u>For In-patient Hospital Services Only</u></p> <p><u>In-Network:</u> 85%</p> <p>After annual deductible is met.</p> <p><u>For Out-patient Services</u></p> <p>Eligible charges are covered at 100%</p>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p>Maternity (No pre-existing conditions apply)</p> <p>Baby Steps Programs for Expectant Mothers</p>	<p><u>Network:</u> Maternity benefits are administered under a global fee charge at the time of delivery. Global fees include antepartum care (visits to doctor prior to delivery), delivery services (vaginal delivery --- with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visit following delivery). Because of the global fee, the \$20 co-payment may not be required at each office visit. Subject to annual deductible and 85% coinsurance.</p> <p>Memorial Hospital Mother and Child Care Center and neo-natal nursery are included as in-network services.</p> <p>Baby Steps is a program offered by Meritain that offer case management to High-risk pregnancies. Eliminate the \$400 inpatient hospital deductible for expectant mothers who enroll in Meritain Health's Baby Step Program. If the calendar year deductible has already been met in 2009, the plan will issue a \$400 credit towards inpatient hospital delivery expenses.</p> <p><u>Out-of-Network:</u> Pre-natal and post-natal office visits and delivery---subject to annual deductible and 65% coinsurance.</p> <p>Baby needs to be enrolled within 31 days of birth.</p>	<p>100% after \$20 co-payment per office visit. 100% after \$30 specialist co-pay per office visit.</p> <p>Delivery fee: 85% after inpatient deductible. A single hospital deductible-payment applies for mother and child providing mother and child are discharged at the same time.</p> <p>Maternity benefits are administered under a global fee charge at the time of delivery, including ante-partum care (doctor visits prior to delivery), delivery services (vaginal delivery – with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visits following delivery).</p> <p>Baby Steps is a program offered by Meritain that offer case management to High-risk pregnancies.</p> <p>Eliminate the \$350 inpatient hospital deductible for expectant mothers who enroll in Meritain Health's Baby Step Program. If the calendar year deductible has already been met in 2009, the plan will issue a \$350 credit towards inpatient hospital delivery expenses.</p> <p>Baby needs to be enrolled within 31 days of birth.</p>	<p>100% after \$20 co-payment per office visit. 100% after \$30 specialist co-pay per office visit.</p> <p>Delivery fee: 85% after inpatient deductible. A single hospital deductible-payment applies for mother and child providing mother and child are discharged at the same time.</p> <p>Maternity benefits are administered under a global fee charge at the time of delivery, including ante-partum care (doctor visits prior to delivery), delivery services (vaginal delivery – with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visits following delivery).</p> <p>Baby Steps is a program offered by Meritain that offer case management to High-risk pregnancies.</p> <p>Eliminate the \$350 inpatient hospital deductible for expectant mothers who enroll in Meritain Health's Baby Step Program. If the calendar year deductible has already been met in 2009, the plan will issue a \$350 credit towards inpatient hospital delivery expenses.</p> <p>Baby needs to be enrolled within 31 days of birth.</p>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p>Mental Health Services <i>(Out-patient)</i></p> <p>Marital Counseling will be a covered benefit.</p>	<p><u>In-Network:</u> 85% after annual deductible is met for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. (Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment. Limited to 50 visits per calendar year. (less out-patient alcoholism/drug abuse visits used).</p> <p><u>Out-of-Network:</u> 65% after annual deductible is met for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. Limited to 50 visits per calendar year. (Less out-patient alcoholism/drug abuse visits used).</p>	<p>Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment for physician services (M.D., Ph.D., and Licensed Clinical Social Worker) per office visit. Limited to 50 visits per calendar year per member when medically necessary (less out-patient alcoholism/drug abuse visits used).</p>	<p>Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment for physician services (M.D., Ph.D., and Licensed Clinical Social Worker) per office visit. Limited to 50 visits per calendar year per member when medically necessary (less out-patient alcoholism/drug abuse visits used).</p>
<p>Occupational Therapy</p>	<p><u>In-Network:</u> \$20 co-payment per visit.</p> <p><u>Out-of-Network:</u> 65% After annual deductible is met.</p>	<p>100% after \$20 co-payment per office visit for up to 50 outpatient visits. Inpatient short-term rehabilitation covered for 60 consecutive days. Long-term rehabilitation is not covered.</p>	<p>100% after \$20 co-payment per office visit for up to 50 outpatient visits. Inpatient short-term rehabilitation covered for 60 consecutive days. Long-term rehabilitation is not covered.</p>
<p>Physical Therapy</p>	<p><u>In-Network:</u> 100% after \$20 co-payment per visit.</p> <p><u>Out-of-Network:</u> 65% after deductible.</p> <p>Treatment plans including frequency and duration are required from the provider.</p>	<p>100% after a \$20 co-payment per office visit for up to 50 outpatient visits.</p> <p>Treatment plans including frequency and duration are required from the provider.</p>	<p>100% after \$20 co-payment per office visit for up to 50 outpatient visits.</p> <p>Treatment plans including frequency and duration are required from the provider.</p>
<p>Orthotic Appliances <i>(such as braces or splints)</i></p>	<p><u>In-Network:</u> 85% After deductible, up to annual maximum.</p> <p><u>Out-of-Network:</u> 65% after annual deductible up to the annual maximum.</p> <p>Annual maximum of \$10,000 per person / per year.</p>	<p>Covered in full. (Some limitations and exclusions apply).</p>	<p>Covered in full. (Some limitations and exclusions apply).</p>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p>Preventive Care –</p> <ul style="list-style-type: none"> • Physical Exam • Well Woman Care (including Pap test) • Mammogram • Blood Screening (plus blood pressure/height and weight) • Sigmoidoscopy • Occult blood • Prostate-Specific Antigen (PSA) • Eligible immunizations: DPT, MM, Tuberculin skin test and annual flu shot. 	<p>IN-NETWORK ONLY</p> <p>Participants age 7 and over</p> <ul style="list-style-type: none"> • All eligible services are covered at 100%, no co-payment, 1 per year • All eligible services are covered at 100%, no co-payment, 1 per year. • Baseline at age 35; 1 per year after age 40. • 1 per year • 1 per year after age 50. • 1 per year after age 40. • 1 per year after age 50. <p>18 years of age and older - only applicable to eligible immunizations. (CDC recommended immunizations are covered at specified ages.)</p>	<p>IN-NETWORK ONLY</p> <p>No Age Limit</p> <ul style="list-style-type: none"> • All eligible services are covered at 100%, no co-payment, 1 per year • All eligible services are covered at 100%, no co-payment, 1 per year. • Baseline at age 35; 1 per year after age 40. • 1 per year • 1 per year after age 50. • 1 per year after age 40. • 1 per year after age 50. <p>18 years of age and older - only applicable to eligible immunizations. (CDC recommended immunizations are covered at specified ages.)</p>	<p>IN-NETWORK ONLY</p> <p>No Age Limit</p> <ul style="list-style-type: none"> • All eligible services are covered at 100%, no co-payment, 1 per year • All eligible services are covered at 100%, no co-payment, 1 per year. • Baseline at age 35; 1 per year after age 40. • 1 per year • 1 per year after age 50. • 1 per year after age 40. • 1 per year after age 50. <p>18 years of age and older - only applicable to eligible immunizations. (CDC recommended immunizations are covered at specified ages.)</p>
<p>Preventive Care - Children</p> <ul style="list-style-type: none"> • Periodic Well Care checkups • Well Baby Care • Immunizations/Inoculations 	<p>Under age 7</p> <p><u>In-Network:</u> All eligible services are covered 100%, no co-payment.</p> <p><u>Out-of-Network:</u> Subject to deductible and 65% coinsurance.</p> <p>(CDC recommended immunizations are covered at specified ages.)</p>	<p>No age limit Coverage for In-Network Only</p> <p>All eligible services are covered 100%, no co-payment.</p>	<p>No age limit Coverage for In-Network Only</p> <p>All eligible services are covered 100%, no co-payment.</p>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p>Prosthesis</p>	<p><u>In-Network:</u> After deductible, plan pays 85% of eligible charges up to annual maximum.</p> <p><u>Out-of-Network:</u> After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges.</p> <p>Annual maximum of \$20,000 per person / per year.</p>	<p>Covered in full with prior approval from Meritain Health.</p>	<p>Covered in full with prior approval from Meritain Health.</p>
<p>Skilled Nursing Facility</p>	<p><u>In-Network:</u> 85% <u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met if medically necessary. No custodial care.</p>	<p>No charge for up to 60 days per calendar year, if medically necessary. No custodial care.</p>	<p>No charge for up to 60 days per calendar year, if medically necessary. No custodial care.</p>
<p>Speech Therapy</p>	<p><u>In-Network:</u> 100% after \$20 co-payment per visit. <u>Out-of-Network:</u> 65% after deductible.</p> <p>No coverage provided for developmental delay or learning disorder.</p>	<p>100% after a \$20 co-payment per office visit for up to 50 outpatient visits.</p> <p>No coverage provided for developmental delay or learning disorder.</p>	<p>100% after \$20 co-payment per office visit for up to 50 outpatient visits.</p> <p>No coverage provided for developmental delay or learning disorder.</p>
<p>Substance Abuse Services <i>(In-patient)</i> <i>Cross-accumulation with mental health.</i></p>	<p><u>In-Network:</u> 85% <u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met and if confined in an approved facility. Limit of 60 days per year. Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional (M.D., Ph.D. and Licensed Clinical Social Worker) (Less inpatient mental health services).</p>	<p>Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional (M.D., Ph.D. and Licensed Clinical Social Worker); covers short-term crisis and acute symptoms or impairment stabilization. Covered at 85% after \$350 deductible per admission; limited to 60 days per member per calendar year. (Less Inpatient mental health services).</p>	<p>Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional (M.D., Ph.D. and Licensed Clinical Social Worker); covers short-term crisis and acute symptoms or impairment stabilization. Covered at 85% after \$350 deductible per admission; limited to 60 days per member per calendar year. (Less Inpatient mental health services).</p>

PLAN COVERAGE	MERITAIN PPO	MERITAIN SELECT HMO	MERITAIN CHA HMO
<p>Substance Abuse Services (Out-patient) Cross-accumulation with mental health.</p>	<p><u>In-Network:</u> 85% <u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met for physician (M.D., Ph.D. and Licensed Clinical Social Worker) services. Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment. Limited to 50 visits per year. (Less out-patient mental nervous visits used).</p>	<p>Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment per office visit (M.D., Ph.D. and Licensed Clinical Social Worker.) Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment.</p> <p>Limited to 50 visits per contract year per member when medically necessary (Less out-patient mental nervous visits used).</p>	<p>Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment per office visit (M.D., Ph.D. and Licensed Clinical Social Worker.) Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment.</p> <p>Limited to 50 visits per contract year per member when medically necessary (Less out-patient mental nervous visits used).</p>
<p>Surgery / In-patient</p>	<p><u>Network:</u> 85% after deductible. <u>Out-of-Network:</u> 65% after deductible of eligible, reasonable, and customary charges.</p>	<p>85% after annual in-patient deductible.</p>	<p>85% after annual in-patient deductible.</p>
<p>Surgery / Out-patient (office)</p>	<p><u>In-Network:</u> 85% after deductible. (Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment). <u>Out-of-Network:</u> 65% after deductible.</p>	<p>100% after \$100 co-payment per procedure for out-patient surgery.</p>	<p>100% after \$100 co-payment per procedure for out-patient surgery.</p>
<p>TMJ (Temporomandibular Joint Syndrome)</p>	<p>Non-Surgical treatment covered at 85% in-network and 65% UCR out of network, subject to deductible up to \$1000 yearly maximum and \$3000 lifetime maximum.</p> <p>Inpatient and Outpatient Hospitalization (Surgical Benefit) is covered at 85% in network and 65% UCR out of network, subject to deductible.</p>	<p>Not Covered</p>	<p>Not Covered</p>
<p>Voluntary Abortion and/or Sterilization</p>	<p>Not Covered</p>	<p>Not Covered</p>	<p>Not Covered</p>

Wisdom Teeth	Coverage for Removal of Impacted Teeth Only.	Not Covered	Not Covered
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PRESCRIPTION BENEFIT- WITH ALL MEDICAL PLANS

Program Administrated by Medco

www.medco.com

1-800-771-0917

Three tier program with use of preferred drug listing called a formulary.

	Participating Retail Pharmacy Up to a 30-day supply	Mail Service Up to a 90-day supply
Generic	\$5	\$12
Brand formulary	\$20	\$45
Brand non-formulary	\$35	\$75
Specialty drugs	\$70	\$150 *

* When clinically appropriate

<p><u>What is a formulary?</u></p> <p>A formulary is a cost-effective solution to help you with select prescription drugs for you and your family. The formulary is a continually updated list of preferred drugs selected by a panel of physicians and pharmacists. A drug on the formulary benefits members as it gives them access to valuable medications at a lower co-payment. Both generic and brand drugs that provide effective, safe, and appropriate drug therapies are listed on the formulary</p>	<p><u>Generic Drugs versus Brand Name Drugs:</u></p> <p><i>Generic Drugs</i> are identical to brand name drugs, but are sold under their chemical generic name. Generic drugs must contain the same active chemical ingredients and be equivalent in strength and dosage from to the brand-name product. The federal Food and Drug Administration regulates the quality, strength and purity of generic drugs.</p> <p><i>Brand-Name Drugs</i> are drugs that are advertised and sold under a product name chosen by the manufacturer. In general, brand-name drugs are more expensive than generic drugs.</p>	<p><u>Mail Service Requirement:</u></p> <p>You may receive your first three refills for long-term or maintenance medications under the retail network service. Your fourth and future refills must be obtained through the mail service to avoid higher co-payments. <u>Long-term or maintenance medications filled at retail after the first three refills will be subject to double the retail co-payments for up to a 30-day supply (\$10 for generic, \$40 for brand, or \$70 for brand non-formulary)</u></p> <p>By using the mail service program you can receive up to a 90 day supply of long-term or maintenance medication for two months worth of retail co-payments. Mail service co-payments are as follows: \$12 generic, \$45 brand, or \$75 brand non-formulary.</p>
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<p><u>Oral Contraceptives:</u></p> <p>Drug treatment for correction of existing pathologies of the reproductive system only.</p> <ul style="list-style-type: none"> To establish medical necessity, physician must fax a letter of medical necessity to Benefit Associate at 574-631-6790. Authorizations will be input into Medco's system and are good for 12 months. <p>No payment will made for expenses incurred:</p> <ul style="list-style-type: none"> For oral contraceptive or contraceptive devices, except when specifically requested by a physician based on medical necessity and for purposes other than contraception. Contraceptive implants, such as Norplant, are not considered Covered Prescription Drugs. For oral and injectable fertility drugs administered in conjunction with artificial insemination, in-vitro fertilization (IVF), GIFT, ZIFT or any other treatment designed
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VISION PLAN

The University of Notre Dame's Vision care is provided through EyeMed. EyeMed vision care offers savings on eye examinations, contact lenses, lens options and accessories, as well as LASIK and PRK laser vision correction procedures. You may choose independent ophthalmologists, optometrists, opticians, and LensCrafters locations throughout the country. A complete provider listing can be viewed at www.enrollwitheyemed.com. There are no claim forms to complete for in-network services.

Vision Care	Member Cost	Out-of-Network Allowance
Exam with dilation as Necessary:	\$0	Up to \$35
Standard Plastic Lenses:		
Single Vision	\$10 co-payment	Up to \$25
Bifocal	\$10 co-payment	Up to \$40
Trifocal	\$10 co-payment	Up to \$55
Lenticular	\$10 co-payment	Up to \$55
Frames:		
Any frame available at provider location	\$0 co-payment, \$130 allowance for any frame plus 20% off balance over \$130	Up to \$45
Lens Options:		
UV Coating	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Scratch-Resistance	\$15	N/A
Standard Polycarbonate	\$40	N/A
Standard Progressive-(add-on to Bifocal)	\$65	N/A
Standard Anti-Reflective	\$45	N/A
Other Add-Ons and Services	20% discount	N/A
Contact Lenses:		
Fit and Follow-up	Up to \$55	N/A
Conventional	\$0 co-payment, plus 15% discount off balance over \$130	Up to \$100
Disposables	\$0 co-payment, plus balance over \$130	Up to \$100
Medically Necessary	\$0 co-payment, plus balance over \$250	Up to \$200
Laser Vision Correction:		
Lasik or PRK From US Laser Network	15% of retail price or 5% off promotional price	N/A
Frequency:		
Examination	Once every 12 months	
Frame	Once every 24 months	
Lenses or Contact Lenses	Once every 12 months	
Vision Premiums per month		
	Individual \$8.32	
	Individual+1 \$15.72	
	Family \$23.04	

VISION PLAN - CONTINUED

MEMBERS MAY UTILIZE THE FOLLOWING PLAN ONCE THE INITIAL VISION BENEFIT PLAN HAS BEEN EXHAUSTED.

Value Added Features:

In addition to the health benefits your EyeMed program offers, members also enjoy additional, value-added features including:

- **Additional Savings:** Save up to 40% off additional complete eyeglass purchases once the funded benefit has been used
- **Laser Vision Correction:** Save 15% off the retail price or 5% off the promotional price of LASIK or PRK procedures.
- **Replacement Contact Lenses Online:** As an added convenience, members can order replacement contact lenses directly online.

Additional Purchases and Out-of-Pocket Discount

Member will receive a 20% discount on remaining balance at participating providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed's Providers professional services, or disposable contact lenses.

Benefits are not provided for services or materials arising from:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes
- Corrective eyewear required by an employer as a condition of employment
- Safety eyewear unless specifically covered under the plan
- Services provided as a result of any Worker's Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state, or subdivisions thereof.
- Plan non-prescription lenses and non-prescription sunglasses (except for 20% discount) Services or materials provided by any other group benefit providing for vision care
- Two pairs of glasses in lieu of bifocals (does not apply to Primary Plan members)
- Services or materials provided by any other group benefit providing for vision care.
- Benefit allowances provide no remaining balance for future use within same benefit period
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except until the next benefit period.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

DENTAL PLANS

PLAN COVERAGE	Delta Premier PPO Group #9541-0001	Delta Preferred PPO, POS Group #5541-0001		
Children Eligibility (due to age)	Children are eligible up to the age of 19. If they are a full-time student they may be covered up to the age of 25. If a child loses eligibility their coverage will terminate the end of the calendar month in which they lose eligibility. You will be required to provide proof of full-time status to the insurance company before any claims are paid.			
Dental Premiums per month	2009 Individual \$15.42 Individual+1 \$27.52 Family \$50.36	2010 Individual \$15.42 Individual+1 \$27.52 Family \$50.36	2009 Individual \$20.02 Individual+1 \$37.52 Family \$67.94	2010 Individual \$20.02 Individual+1 \$37.52 Family \$67.94
Delta Dental Premier	Delta Dental PPO (Point-of-Service)			

- If enrolling in a dental plan a 2-year commitment is required (may switch dental plans during open enrollment).
- Member ID# is faculty/staff member's actual social security number.
- Delta Dental Consumer Toolkit – www.consumertoolkit.com

The Consumer Toolkit allows a very secure environment for covered members and their spouses to easily:

- Verify eligibility of subscriber and dependents;
- Review up-to-date benefits information (such as how much of your yearly benefit has been used to date, how much is still available to use, and levels of coverage for specific dental services).
- Review specific claims transactions, reimbursements, and payments; and
- Print your own member ID cards.

Group #9541-0001, 0099		University of Notre Dame DU LAC	Group #5541-0001, 0099					
			PPO Dentist		Premier Dentist		Nonparticipating Dentist	
Plan Pays	You Pay		Plan Pays	You Pay	Plan Pays	You Pay	Plan Pays	You Pay
Class I Benefits								
100%	0%	Diagnostic and Preventive Services - Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and fluoride treatments).	100%	0%	100%	0%	100%	0%
100%	0%	Emergency Palliative Treatment - Used to temporarily relieve pain.	100%	0%	100%	0%	100%	0%
100%	0%	Bitewing Radiographs – Bitewing X-rays.	100%	0%	100%	0%	100%	0%
Class II Benefits								
50%	50%	Oral Surgery Services - Extractions and dental surgery, including preoperative and postoperative care.	80%	20%	50%	50%	50%	50%
50%	50%	Endodontic Services - Used to treat teeth with diseased or damaged nerves (for example, root canals).	80%	20%	50%	50%	50%	50%
50%	50%	Periodontic Services - Used to treat diseases of the gums and supporting structures of the teeth.	80%	20%	50%	50%	50%	50%
50%	50%	Relines and Repairs - Relines and repairs to bridges and dentures.	80%	20%	50%	50%	50%	50%
50%	50%	Minor Restorative Services - Used to repair teeth damaged by disease or injury (for example, fillings).	80%	20%	50%	50%	50%	50%
50%	50%	Sealants - Used to prevent decay of pits and fissures of permanent back teeth.	80%	20%	50%	50%	50%	50%
50%	50%	Major Restorative Services - Used when teeth cannot be restored with another filling material (for example, crowns).	Offered Under Class III Benefits		Offered Under Class III Benefits		Offered Under Class III Benefits	
50%	50%	Full Mouth Radiographs	80%	20%	50%	50%	50%	50%
50%	50%	All Other Radiographs – All other X-rays, as required and in conjunction with the diagnosis of a specific condition requiring treatment.	80%	20%	50%	50%	50%	50%
Class III Benefits								
Offered under Class II Benefits		Major Restorative Services - Used when teeth cannot be restored with another filling material (for example, crowns)	50%	50%	50%	50%	50%	50%
50%	50%	Prosthodontic Services - Used to replace missing natural teeth (for example, bridges and dentures)	50%	50%	50%	50%	50%	50%
Class IV Benefits								
50%	50%	Orthodontic Services (no age limit) - Used to correct malposed teeth (for example, braces)	50%	50%	50%	50%	50%	50%
\$1,000		Maximum Payment – The person total per benefit year on Class I, Class II and Class III Benefits is:	\$1,500					
\$1,000		The lifetime maximum for each eligible person for Class IV Benefits will not exceed:	\$1,000					
\$50/\$150		Deductible –The deductible per person total per benefit year limited to a maximum deductible per family per benefit year on Class II and Class III Benefits is:	\$50/\$150					
		The deductible does not apply to Class I or Class IV Benefits.						

This document is intended as a supplement to your Dental Care Certificate and Summary of Dental Plan Benefits. Please refer to your certificate and summary for policy exclusions and limitations.

Customer Service toll-free number (800) 524-0149