

Healthy Living Is Important

for you, your family, and campus



UNIVERSITY OF
NOTRE DAME



2010 BENEFITS ENROLLMENT GUIDEBOOK

WHAT TO KNOW ABOUT OPEN ENROLLMENT

Date: October 21 through November 6, 2009

How to Enroll: Online at www.openenroll.nd.edu 24 hours a day/7 days a week

or

For hourly employees only:
Return your Personal Benefits Worksheet to:

Office of Human Resources
200 Grace Hall

Where to Enroll Online: Human Resources
Second Floor, Grace Hall

Campus Clusters:
Architecture (Bond Hall) Room G022
College of Business Rooms L002/L004
Coleman Morse Room 107
Hesburgh Library, Main Floor
DeBartolo Hall, Room 133
LaFortune Student Center Room 16

Enrollment Deadline: November 6, 2009 (If enrollment is received after this date, the Office of Human Resources cannot guarantee issuance of insurance cards by January 1, 2010.)

Irish Health/Benefits Open House: Date: October 21 and 22, 2009
Location: Rolfs Sports Recreation Center
Time: October 21 - Noon to 7:00 p.m.
October 22 - 7:00 a.m. - 11:00 a.m.

- Free Health Screenings offered by Memorial Health and Lifestyle Center for Web MD's Health Quotient
- Representatives from benefit plans will be present to answer your questions.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

TABLE OF CONTENTS

IMPORTANT QUESTIONS REGARDING ENROLLMENT	3
WHAT TO KNOW ABOUT ENROLLING ONLINE	4
2010 PROVIDER CONTACTS	5
WHAT DO THE MEDICAL OPTIONS MEAN?	6
HOW DO THE OPTIONS WORK?	7
MONTHLY MEDICAL, DENTAL & VISION RATES FOR FACULTY AND STAFF	8
SUPPLEMENTAL & DEPENDENT LIFE INSURANCE RATES	9
MEDICAL COMPARISON CHART	10
PRESCRIPTION DRUG	15
DENTAL	17
DENTAL COMPARISON CHART	18
VISION	19
LIFE INSURANCE	20
FLEXIBLE SPENDING ACCOUNT (FSA) OPTIONS	21
FSA TAX-SAVING EXAMPLE	22
FREQUENTLY ASKED QUESTIONS	23
OPEN ENROLLMENT LIAISONS	30

IMPORTANT QUESTIONS REGARDING ENROLLMENT

Question	Answer
Do I Need to Enroll?	All faculty and staff are required to enroll by November 6, 2009. If you do not, you will be defaulted to your 2009 benefit elections and you will not have a Flexible Spending Account.
How Do I Make Changes?	You may make changes online 24-hours-a-day at http://openenroll.nd.edu . For hourly staff who elect to complete the worksheet: Return your worksheet to 200 Grace Hall.
When Does Coverage Begin?	All benefit elections are effective January 1, 2010.
What if I'm Not Making Any Changes?	Even if you are not making changes to your coverage, you must confirm your benefit elections by enrolling online.
Will I Receive Confirmation of My Changes?	All hourly staff will receive a Confirmation Statement in late November detailing their benefit elections (even if your coverage did not change). All other faculty and staff will have access to their confirmation statement online. You have until December 11 to make corrections due to an unexpected error.
* Please Note: This year will be the last year that hourly staff will receive this guidebook and enrollment worksheet. Next year all staff will need to enroll online.	

WHAT TO KNOW ABOUT ENROLLING ONLINE

Before accessing the online enrollment system:

- Have your dependent information available including Social Security numbers and birth dates.
- Have the name and policy number of any other medical insurance coverage that you may have for your spouse and/or dependent(s).
- If you are enrolling a dependent between the ages of 19 and 25, you will need to confirm full-time student status.

Steps for accessing the Online Enrollment system:

- Access the online enrollment screen at: <http://openenroll.nd.edu>.
- Log on with your NetID and password.
- Make your benefit elections and enter dependent information where applicable.
- **Confirm** your elections by reviewing and verifying the accuracy of your choices.
- If you are requesting more than a \$100,000 increase in life insurance, more than one-time your annual salary increase, or adding supplemental or dependent life insurance complete an Evidence of Insurability (EOI) form. For faculty and staff, the form is available for on-line submission. For dependents (including spouses), the form is available on the open enrollment website.

Recommended browsers:

- Window Users - Netscape Communicator 4.76 and above or Microsoft Internet Explorer 5.0 and above
- Macintosh Users - Netscape Communicator 4.76 and above.

For Benefit questions: Contact askHR at 631-5900 or online at
www.openenroll.nd.edu

For Web or NetID questions: Contact the OIT Help Desk at 631-8111
or online at <https://websupport.nd.edu>.

2010 PROVIDER CONTACTS

Plan	Provider	Phone #	Internet Address
MEDICAL			
MERITAIN PPO Anchor hospital - St. Joseph Regional Med Center	Meritain Health	1-888-668-6855	www.meritain.com
Local Network	Select Health	1-888-668-6855	www.selecthealthnetwork.com
National Network	Beech Street	1-800-432-1776	www.beechstreet.com
Midwest Behavioral Health Network	New Avenues	1-800-223-6246	www.newavenuesonline.com
MERITAIN CHA HMO Anchor hospital - Memorial Hospital	Meritain Health	1-888-668-6855	www.meritain.com
Network	CHA Network	1-888-689-2242	www.chanetwork.com
MERITAIN SELECT HMO Anchor hospital - St. Joseph Regional Med Center	Meritain Health	1-888-668-6855	www.meritain.com
Local Network	Select Health	1-888-668-6855	www.selecthealthnetwork.com
Midwest Behavioral Health Network	New Avenues	1-800-223-6246	www.newavenuesonline.com
PRESCRIPTION DRUG	Medco	1-800-711-0917	www.medco.com
DENTAL			
Delta Premier (PPO)	Delta Dental	1-800-524-0149	www.deltadental.com
Delta Preferred (PPO, POS)	Delta Dental	1-800-524-0149	www.deltadental.com
VISION	EyeMed	1-866-939-3633	www.eyemedvisioncare.com www.enrollwiththeyemed.com
LIFE INSURANCE	Minnesota Life	1-800-843-8358	www.minnesotalife.com
FLEXIBLE SPENDING ACCOUNTS	Meritain Health	1-866-448-1696	www.meritain.com

WHAT DO THE MEDICAL OPTIONS MEAN?

The University offers two types of medical options:

Preferred Provider Organization (PPO) Managed By Meritain Health

An organization that establishes contracts with a network of physicians and hospitals to provide health care services while accepting a discount for the services they provide. PPO members must pay additional fees for utilizing services outside the network.

Health Maintenance Organization (HMO) Managed By Meritain Health

An organization that contracts with individuals, employers, physicians, and the government to provide comprehensive health care services to enrolled members at a set fee per member, per month.

Some definitions to help you understand the medical options:

Term	Definition
In-Network	Providers who participate in a medical plan network. These providers have agreed to accept a discounted fee for their services.
Co-Payment	A flat, per-service fee that is paid up front by the employee for services such as physician office visits. These fees do not apply to deductible.
Deductible	The dollar amount that must be paid each plan year by the employee before medical and/or dental plans begin to pay benefits for certain covered expenses.
Co-Insurance	The percentage of the cost the employee is responsible for after deductibles are met. The amount will differ between in-network and out-of-network but is limited to the Out-of-Pocket Limit.

Programs for All Plans

Baby Steps - All expectant mothers are provided educational material and counseling in general health, nutrition, and appropriate pre-natal care. At-risk expectant mothers receive additional consultation during pregnancy. If you elect to participate within the first-trimester, your hospital admissions deductible will be waived.

Nurse Line - 24-hour access to health professionals who can answer your immediate health questions. Call 1-888-668-6855.

Club Health - Club Health is a program designed to help keep you the healthiest you can be. Club Health is available to members with chronic illnesses and conditions like asthma, diabetes, or heart disease. This free program gives you the tools and information you need to manage your health.

HOW DO THE OPTIONS WORK?

PPO Plan:

The Meritain PPO Plan includes:

In-Network Services	Out-of-Network Services
\$400 individual deductible	\$800 individual deductible
Once deductibles are met for eligible services:	
Covered at 85%	Covered at 65% of usual and customary charges
Nationwide coverage for both routine and emergency medical care.	
Flexibility to visit physicians both in-network and out-of-network.	
No requirement to choose a primary care physician.	

HMO Plans:

Meritain CHA HMO, Meritain Select HMO:

Both options provide plan participants with local, in-network coverage only. Life-threatening emergencies that may occur while out of the in-network area are also covered. For example, situations that require immediate medical attention would be considered life-threatening emergencies and would be covered. However, routine medical care would not be considered a life-threatening emergency and; therefore, would not be covered outside of your service area. Plan coverage is generally based on co-payments and not out-of-pocket deductibles except for inpatient hospitalization where a deductible & coinsurance is applicable.

The HMO Plans Include:

- No designation of primary care physician
- No referrals for specialist physician in the network
- Co-payments for:
 - Primary Care Physician - \$20
 - Specialist Physician - \$30

Women's Health & Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1988. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses
- Treatment of physical complications of the mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

2010 MONTHLY RATES FOR FULL-TIME FACULTY AND STAFF

Medical	Individual Without HQ	Individual With HQ	Individual + 1 Without HQ	Individual + 1 With HQ	Individual + 1 Spouse/ Emp With HQ	Family Without HQ	Family With HQ	Family Spouse / Emp With HQ
Meritain PPO	\$64.00	\$54.00	\$205.00	\$195.00	\$190.00	\$227.00	\$217.00	\$212.00
Meritain Select HMO	\$38.00	\$28.00	\$132.00	\$122.00	\$117.00	\$154.00	\$144.00	\$139.00
Meritain CHA HMO	\$52.00	\$42.00	\$197.00	\$187.00	\$182.00	\$216.00	\$206.00	\$201.00

NOTE: Rates include medical and prescription coverage

HQ = WebMD HealthQuotient

Dental	Individual	Individual + 1	Family
*Delta Premier (PPO) - 2010	\$16.36	\$29.18	\$53.46
*Delta Preferred (PPO POS) - 2010	\$21.08	\$39.50	\$71.50
*Delta Premier (PPO) - 2011	\$17.26	\$30.78	\$56.44
*Delta Preferred (PPO POS) - 2011	\$22.24	\$41.68	\$75.46

*NOTE: Mandatory two-year enrollment with a guaranteed rate structure. Rates through 2011

Vision	Individual	Individual + 1	Family
Eye Med	\$8.32	\$15.72	\$23.04

MONTHLY PART-TIME RATES

Plan	Individual	Individual + 1	Family
Medical			
- Meritian PPO	\$497.00	\$993.00	\$1489.00
- Meritian Select HMO	\$425.00	\$850.00	\$1275.00
- Meritian CHA HMO	\$493.00	\$985.00	\$1478.00
NOTE: Rates include medical and prescription coverage			
Dental			
- Delta Premier (PPO) - 2010	\$29.22	\$52.08	\$95.48
- Delta Preferred (POS) - 2010	\$35.12	\$65.82	\$119.18
- Delta Premier (PPO) - 2011	\$30.84	\$54.98	\$100.78
- Delta Preferred (POS) - 2011	\$37.06	\$69.46	\$125.78
Vision			
EyeMed	\$8.32	\$15.72	\$23.04

Part-time employees who elect medical coverage through the University and complete HQ are eligible for the \$10 premium reduction.

SUPPLEMENTAL LIFE INSURANCE RATES

Your Age	Monthly Rate per \$1,000 of Coverage	Your Age	Monthly Rate per \$1,000 of Coverage
<25	\$.063	45-49	\$.157
25-29	\$.068	50-54	\$.219
30-34	\$.086	55-59	\$.390
35-39	\$.094	60-64	\$.590
40-44	\$.103	65-69	\$1.286
		70+	\$1.792

How To Calculate Your Monthly Rate For Supplemental Life Insurance Coverage

	Example		My Information
Full Time	Yes		
Age	32		
Annual Salary	\$40,000		
Additional coverage	2	x	
(if applicable, round up to the nearest thousand)	\$80,000	=	
Divide by 1,000	1000	/	
	80	=	
Rate per age (above)	\$.086	x	
	\$6.88	=	
The example employee will pay \$6.88 per month for \$80,000 of Supplemental Life Insurance Coverage.			

Dependent Life Insurance	Rate
Spouse \$12,500	\$3.36
Spouse \$25,000	\$6.72
Child(ren) \$5,000	\$0.76
Child(ren) \$10,000	\$1.52

NOTE: All life insurance premiums are an after-tax deduction.

MEDICAL COMPARISON CHART - SUMMARY ONLY

When you are deciding which medical option to choose, there are a number of factors to consider. Because each medical option has unique features, it is important for you to take a few moments to review the chart to gain a better understanding of the differences among the medical plans. Please note that this chart is not all inclusive.

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
In-Network Hospital	St. Joseph Regional Medical Center, Goshen, LaPorte & Lakeland	St. Joseph Regional Medical Center, Goshen, LaPorte & Lakeland	Memorial Hospital and Elkhart General Hospital
Provider Network	Select Health (Local Network) Beech Street (National Network) New Avenues (Midwest Behavioral Health Network)	Select Health New Avenues (Midwest Behavioral Health Network)	Community Health Alliance (CHA) Network
Deductible	<u>In-Network:</u> \$400 (Individual) \$800 (Family) <u>Out-of-Network:</u> \$800 (Individual) \$1600 (Family) In and out-of-network deductibles do not cross accumulate	For In-patient Hospital Services Only \$350 (Individual) \$700 (Family)	For In-patient Hospital Services Only \$350 (Individual) \$700 (Family)
Co-Insurance (Your share of eligible expenses.)	<u>In-Network:</u> 85% of eligible charges after deductible. (Employee pays remaining 15%.) <u>Out-of-Network:</u> 65% of eligible, reasonable, and customary charges after deductible. (Employee pays remaining 35% plus any amounts above reasonable & customary.)	For In-patient Hospital Services Only 85% of eligible charges after inpatient deductible. (Employee pays remaining 15%)	For In-patient Hospital Services Only 85% of eligible charges after inpatient deductible. (Employee pays remaining 15%)
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 can meet this limit for the whole family.)	<u>In-Network:</u> \$1250 (Individual) \$3000 (Family) <u>Out-of-Network:</u> \$2500 (Individual) \$5000 (Family) In and out-of-network deductibles do not cross accumulate	For In-patient Hospital Services Only \$800 (Individual) \$1,600 (Family)	For In-patient Hospital Services Only \$800 (Individual) \$1,600 (Family)
Physician Office Visits (Co-payments)	<u>In-Network:</u> 100% after \$20 co-payment per physician office visit. The co-payment is required even after deductible is met. <u>Out-of-Network:</u> 65% of eligible, reasonable, and customary charges after annual deductible. (Employee pays 35% plus any amounts above reasonable & customary.)	100% after \$20 co-payment per primary care physician office visit. (Family and General Practitioner, Internist, Pediatrician, or OB/GYN). 100% after \$30 co-payment per specialist physician office visit.	100% after \$20 co-payment per primary care physician office visit. (Family and General Practitioner, Internist, Pediatrician, or OB/GYN). 100% after \$30 co-payment per specialist physician office visit.

This chart does not replace the legal plan documents or contracts for each of the benefit plans and should not, in any way, be considered a contract.

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
Allergy testing	<u>In-Network</u> 85% after deductible <u>Out-of-Network:</u> 65% after deductible	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	<u>In-Network & Out-of-Network</u> 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.
Children Eligibility (Note: If you are enrolling a dependent age 19-25, you must verify full-time student status on the open enrollment application.)	Children are eligible until age 19 as long as dependent on employee for at least 50% of financial support. If children are full-time students (at least 12 credit hours) and unmarried, they remain eligible until age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.	Children are eligible until age 19 as long as dependent on employee for at least 50% of financial support. If children are full-time students (at least 12 credit hours) and unmarried, they remain eligible until age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.	Children are eligible until age 19 as long as dependent on employee for at least 50% of financial support. If children are full-time students (at least 12 credit hours) and unmarried, they remain eligible until 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)	\$20 co-pay (20 annual visits)
Diabetic Supplies Covered as part of the Prescription Drug Program	N/A	N/A	N/A
Durable Medical Equipment	<u>In-Network:</u> 85% of eligible charges up to annual maximum after deductible. <u>Out-of-Network:</u> 65% of eligible, reasonable, and customary charges after deductible up to annual maximum. Annual maximum of \$15,000 per person/per year.	Covered in full with prior approval from Meritain Health.	Covered in full with prior approval from Meritain Health.
Emergency Services (Out-of-Area/Out-of-State)	85% after deductible. If you are out of the area at the time emergency treatment is required and it is not life threatening, visit the Beech Street web site at www.beechstreet.com or call 1-800-432-1776 to locate the nearest network provider.	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). Contact Meritain Health to notify them of the emergency treatment. Routine medical care and non-emergency care received out of town is not covered.	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). Contact Meritain Health to notify them of the emergency treatment. Routine medical care and non-emergency care received out of town is not covered.

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
	If the medical emergency turns into an inpatient hospital admission, the physician or employee should contact Meritain Health within 48 hours to request pre-certification.	If the medical emergency turns into an inpatient hospital admission, the physician or employee should contact Meritain Health within 48 hours to request pre-certification.	If the medical emergency turns into an inpatient hospital admission, the physician or employee should contact Meritain Health within 48 hours to request pre-certification.
Emergency Services (In-Area)	<p>Emergency Services (In-Area)</p> <p>85% after deductible.</p> <p><u>Out-of-Network:</u> 65% after deductible of eligible, reasonable and customary charges.</p> <p>\$50 co-payment for services provided at Select's Urgent Care Centers</p>	<p>\$120 co-payment for Emergency Room (waived if patient is admitted).</p> <p>\$40 co-payment for services provided at Select Urgent Care Centers</p>	<p>\$120 co-payment for Emergency Room (waived if patient is admitted).</p> <p>\$40 co-payment for Urgent Care provided at Medpoint and other CHA Urgent Care providers.</p> <p>\$25 co-pay for Urgent Care at Medpoint Express</p>
Genetic Testing	Not Covered	Not Covered	Not Covered
Hospital Room & Board (Benefits are provided up to the semi-private room rate)	<p><u>In-Network:</u> 85% after deductible.</p> <p><u>Out-of-Network:</u> 65% after deductible of eligible, reasonable and customary charges.</p>	85% after annual inpatient deductible.	85% after annual inpatient deductible.
Laboratory & X-Ray	<p><u>In-Network:</u> 85% after deductible.</p> <p><u>Out-of-Network:</u> 65% after deductible of eligible, reasonable and customary charges.</p>	100%	100%
Maternity (No pre-existing conditions apply)	<p><u>In-Network:</u> 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). \$20 co-payment may not be required at each office visit. Subject to annual deductible and paid at 85%. Memorial Hospital Mother and Child Care Center and Neonatal Nursery are included as in-network services.</p> <p><u>Out-of-Network:</u> Pre-natal and post-natal office visits and delivery. Subject to annual deductible and paid at 65%. 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 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. 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). 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 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. 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). Baby needs to be enrolled within 31 days of birth.</p>

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
Mental Health Services (In-patient)	<p><u>In-Network:</u> 85% after annual deductible for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services.</p> <p><u>Out-of-Network:</u> 65% after annual deductible for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. A Meritain Clinical Case Manager will determine medical necessity and duration in collaboration with your therapist.</p>	<p>85% after annual in-patient deductible. (M.D., Ph.D., and Licensed Clinical Social Worker).</p> <p>A Meritain Clinical Case Manager will determine medical necessity and duration in collaboration with your therapist.</p>	<p>85% after annual in-patient deductible. (M.D., Ph.D., and Licensed Clinical Social Worker).</p> <p>A Meritain Clinical Case Manager will determine medical necessity and duration in collaboration with your therapist.</p>
Mental Health Services (Out-patient)	<p><u>In-Network:</u> 85% after annual deductible 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.)</p> <p>Marriage counseling included.</p> <p><u>Out-of-Network:</u> 65% after annual deductible for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services.</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.</p> <p>Marriage counseling included.</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.</p> <p>Marriage counseling included .</p>
Physical Therapy	<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 \$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>
Prescription Drugs	Note: Automatically enrolled when medical coverage with Notre Dame is elected. Prescription Drug benefits are administered by Medco.		
Preventive Care	<u>Age 7 and Older</u>	No Age Limit - Coverage for In-Network Only	No Age Limit -Coverage for In-Network Only
- physical exam	<p>All eligible services are covered at 100%, no co-payment, 1 per year.</p> <p><u>Out-of-Network:</u> 65% after annual deductible</p>	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.
- well women care (includes PAP smear)	<p>All eligible services are covered at 100%, no co-payment, 1 per year.</p> <p><u>Out-of-Network:</u> 65% after annual deductible</p>	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.

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
- mammogram	Baseline at age 35; 1 per year after age 40. <u>Out-of-Network:</u> 65% after annual deductible	Baseline at age 35; 1 per year after age 40.	Baseline at age 35; 1 per year after age 40.
- blood screening (plus blood pressure/height and weight)	1 per year. <u>Out-of-Network:</u> 65% after annual deductible	1 per year.	1 per year.
- colonoscopy or sigmoidoscopy	1 per year after age 50. Covered prior to age 50 if parent, sibling or grandparent has had colorectal polyps or cancer. <u>Out-of-Network:</u> 65% after annual deductible	1 per year after age 50. Covered prior to age 50 if parent, sibling or grandparent has had colorectal polyps or cancer	1 per year after age 50. Covered prior to age 50 if parent, sibling or grandparent has had colorectal polyps or cancer
- occult blood	1 per year after age 40. <u>Out-of-Network:</u> 65% after annual deductible	1 per year after age 40.	1 per year after age 40.
- prostate -specific antigen (PSA)	1 per year after age 50. <u>Out-of-Network:</u> 65% after annual deductible	1 per year after age 50.	1 per year after age 50.
- Immunizations - Recommended Immunizations (Department of Health & Human Services - Center for Disease Control & Prevention) in the schedule of Benefits Table.	These immunizations are to be covered for all members that meet the appropriate age requirements for the immunizations.	These immunizations are to be covered for all members that meet the appropriate age requirements for the immunizations.	These immunizations are to be covered for all members that meet the appropriate age requirements for the immunizations.
Preventive Care – (Children) • Periodic Well Care Check-ups • Well Baby Care • Immunizations/ Inoculations	Under Age 7 <u>In-Network:</u> All eligible services are covered 100%, no co-payment. <u>Out-of-Network:</u> Subject to deductible and 65% coinsurance. (State mandated immunizations are covered at any age.)	No age limit– Coverage for In-Network Only All eligible services are covered 100%, no co-payment.	No age limit– Coverage for In-Network Only All eligible services are covered 100%, no co-payment.
Surgery/In-patient	<u>In-Network:</u> 85% after deductible. <u>Out-of-Network:</u> 65% after deductible of eligible, reasonable, and customary charges.	85% after annual in-patient deductible.	85% after annual in-patient deductible.
Surgery/Out-patient (office)	<u>In-Network:</u> 85% after deductible. (Services are not considered the same as a routine office visit and do not qualify for payment at 100% after a \$20 co-payment.) <u>Out-of-Network:</u> 65% after deductible.	100% after \$100 co-payment per procedure for out-patient surgery.	100% after \$100 co-payment per procedure for outpatient surgery.
Voluntary Abortion and/or Sterilization	Not Covered	Not Covered	Not Covered

PRESCRIPTION DRUG

Medco

You are automatically enrolled in the prescription drug plan administered by Medco when you enroll in one of the medical options. Employees will receive one ID card. The ID card will include medical and prescription information.

The **prescription drug** plan provides retail and mail services. Under the retail network service, you can visit any in-network pharmacy for your short-term prescription drug needs. For a 30-day drug supply, the following co-payments apply:

- \$5 for generic drugs
- \$20 for preferred brands
- \$35 for non-preferred brands
- \$70 for specialty drugs

If you visit an out-of-network pharmacy, you must pay the prescription drug cost in full and then file a claim for reimbursement. Medco will reimburse the cost of the prescription drug minus the applicable co-payment.

The **mail service** program must be used for maintenance or long-term medications. This will save you time and

money, as you will receive a 90-day supply delivered to your home for the following co-pays:

- \$12 for generic drugs
- \$45 for preferred brands
- \$75 for non-preferred brands
- \$150 for specialty drugs

Medco offers participants several online services such as:

- Benefit plan information
- Coverage comparisons on home delivery, retail brand-name, and generic medications
- Online prescription orders, tracking prescription status, and viewing up to 18 months of prescription history.

For more information about Medco, visit www.medco.com

GENERIC DRUGS VS. BRAND-NAME DRUGS

Generic Drugs: Generic drugs 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 to the brand-name product. Generic drugs are regulated by the Federal Food and Drug Administration to ensure the quality, strength, and purity of generic drugs.

Brand-Name Drugs: Brand-name drugs 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.

Specialty Drugs - Many self injectable medications are dispensed by a Specialty Pharmacy.

What is a Formulary?

A formulary is a cost-effective solution to help you 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.

SPECIALTY DRUGS & MEDICATIONS

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service

Over the past several years, specialty drugs have been introduced in the marketplace. Currently there are several hundred specialty drugs in the drug pipeline pending FDA approval for release in the next few years. Specialty drug spend is one of the fastest growing components of our pharmaceutical drug costs. We have been partnering with Accredo Health Group Inc., Medco's specialty pharmacy to provide services to our members, which provides benefit consistency and consistency in the application of clinical protocols.

Accredo, Medco's specialty pharmacy is dedicated to serving the needs of patients living with complex conditions that require specialty medications. If you are already using Accredo, you are aware firsthand of the excellent services which they provide. Accredo provides:

- Enhanced clinical training, privacy and support
- 24/7 access to specialized nurses and pharmacists
- Access to products and services
- Compliance monitoring and side-effect mentoring
- Refill reminders
- Benefit consistency
- Shipping convenience

If you or a family member are prescribed a specialty medication, Accredo may be reaching out to you and your physician.

DENTAL

The University offers two dental plan options:

- Delta Premier
- Delta Preferred (PPO, POS)

You also have the option to waive dental coverage. If you decline dental coverage, you will not be able to make a dental election until the next Open Enrollment period, unless you have a “qualifying life event”.

How the Options Work

Delta Premier and Delta Preferred (PPO, POS)

If you enroll in a Delta Dental Plan, you must fulfill a two-year commitment before opting out of dental coverage.

Delta is a fee-for-service dental benefit program that allows you to choose any licensed dentist for your care. If you choose a dentist who has signed a contract with Delta Preferred or Delta Premier, you will pay only your deductible (waived for preventive care and orthodontia) and coinsurance for covered services. If you choose a non-participating dentist, you will still be covered. However, you will be responsible for any difference between Delta Premier’s and Delta Preferred’s approved fee-for-service and the non-participating dentist’s fee.

For the directory of Delta participating dentists and a complete list of covered services, visit www.deltadental.com

Delta Dental Consumer Toolkit - www.toolkitsonline.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.

The privacy of your benefits information is assured. Delta Dental employs state-of-the-art, ultra-secure computer technology to protect your personal information.

For questions regarding your benefits, please contact the customer service department at 1-800-292-0626.

DENTAL COMPARISON CHART

When you are deciding which dental option to choose, please consider the features of each plan and take a few moments to review the comparison chart to gain a better understanding of the differences between the options.

Plan Coverage	Delta Premier		Delta Preferred (PPO, POS)	
	Participating Dentist Plan Pays	Non-Participating Dentist Plan Pays	Participating Dentist Plan Pays	Non-Participating Dentist Plan Pays
Network	Delta Premier	Other Dentists	Delta Preferred	Delta Premier and Other Dentists
Deductibles	\$50 for basic and major services, limit of \$150 per family		\$50 for basic and major services, limit of \$150 per family	
Diagnostic & Preventive Procedures	100%	100% of Usual & Customary	100%	100% of Usual & Customary
Basic Services	50% (after deductible)	50% of Usual & Customary (after deductible)	80% (after deductible)	50% of Usual & Customary (after deductible)
Major Services	50% (after deductible)	50% of Usual & Customary (after deductible)	50% (after deductible)	50% of Usual and Customary (after deductible)
Annual Benefit	\$1,000 per person per year		\$1,500 per person per year	
Orthodontics	50% Maximum lifetime benefit of \$1,000		50% Maximum lifetime benefit of \$1,000	
Children Eligibility (<i>due to age</i>)	Children are eligible up to the age of 19. If they are a full-time student they may be covered up to age of 25. If a child loses eligibility their coverage will terminate the end of the calendar month in which they lose eligibility			

This chart does not replace the legal plan documents or contracts for each of the benefit plans and should not, in any way, be considered a contract.

NOTE: Delta Dental does not send payments to non-participating dentists. Instead, Delta Dental sends payment directly to you. You will be responsible for paying the dentist whatever he or she charges.

Did you know that if you go to a Delta Premier or Delta Preferred dentist, Delta Dental will pay that dentist directly based on the dentist's submitted fee or Delta's Usual and Customary Rate (UCR), whichever is less? If Delta's UCR is lower than the dentist's fee, the dentist cannot charge you the difference. That means you are responsible only for your coinsurance and deductibles, if any, for covered services.

Example #1: If a Delta Premier or Delta Preferred dentist charges \$100 for a service covered at 100%, and if Delta Dental's UCR for that service is \$90, Delta will pay the dentist \$90 and you will owe nothing. The dentist cannot charge you the \$10 difference. If you go to a non-participating dentist, you will still be covered. However, you may have to pay more out-of-pocket, because Delta's payment will be based on the submitted fee from the non-participating dentist.

Example #2: If a non-participating dentist charges \$100 for a service covered at 100%, and if Delta Dental's non-participating dentist fee for that service is \$80, Delta will reimburse you \$80, and you will owe the dentist \$100.

VISION

EyeMed allows you to visit independent ophthalmologists, optometrists, opticians, and LensCrafters, Pearle Vision, Target, Sears, and J.C. Penney Optical locations all across the country. Claim forms are not required for in-network services.

Dependents between the ages of 19 and 25 are considered eligible if they are full-time students.

Vision Care Service	Member Cost	Out-of-Network Allowance
Exam with Dilation as Necessary: (Glasses) Once a calendar year	No Copay	Up to \$35
Standard Plastic Lenses: Every 12 months		
Single Vision	\$10 Copay	Up to \$25
Bifocal	\$10 Copay	Up to \$40
Trifocal	\$10 Copay	Up to \$55
Lenticular	\$10 Copay	Up to \$55
Frames: Any frame available at provider location	No Copay, \$130 allowance for any frame plus 20% off balance over \$130	Up to \$65
Every 24 months		
Lens Options: Every 12 months		
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: Every 12 months	Exam - No Copay	
Exam and Fit	Fit - Up to \$55	
Conventional	No Copay, plus 15% discount off balance over \$130	Up to \$104
Disposables	No Copay, plus balance over \$130	Up to \$104
Medically Necessary	No Copay, plus balance over \$250	Up to \$200

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.

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 for LASIK or PRK procedures.
- **Replacement Contact Lenses Online:** As an added convenience, members can order replacement contact lenses directly online.

LIFE INSURANCE

Group Life Insurance

The University of Notre Dame Group Life Insurance program provides a \$25,000 basic life insurance benefit and accidental death and dismemberment (AD&D) coverage to full-time faculty and staff through Minnesota Life. Life insurance coverage provides a benefit to your survivors in the event of your death. AD&D insurance provides a benefit in the event of your death as a result of an accident or if you suffer a covered loss. The University pays the entire cost of this coverage for eligible employees.

Supplemental Life Insurance

You may supplement the basic coverage provided by the University by purchasing additional employee paid life insurance available to all eligible faculty and staff. Supplemental Life insurance coverage also includes accidental death and dismemberment (AD&D) coverage. Supplemental Life insurance may be purchased in multiples of your annual salary, between 1 to 10 times and premiums are deducted on an after-tax basis.

Evidence of insurability may be required if:

- You elect to increase your supplemental coverage more than 1X your salary or \$100,000
- You are electing supplemental coverage for the first time
- You have previously cancelled supplemental coverage

If evidence of insurability is necessary, approval is required before a change in coverage will occur. You will receive information on the coverage decision directly from Minnesota Life.

Dependent Life Insurance

You may elect dependent life coverage for your spouse and dependent children*. Evidence of insurability will be required if you are requesting coverage for a dependent for the first time, if you are increasing the amount of coverage, or if you have previously cancelled dependent coverage.

Option	Amount
Spouse	\$12,500
	\$25,000
Child(ren)	\$5,000 (for each child covered)
	\$10,000

*Children are eligible until age 19 or until age 25 if an unmarried, full-time student who is still considered a dependent

Special Rules for Reduction in Coverage:

Once you attain age 65, the amount of the Supplemental Life and Accidental Death & Dismemberment insurance shall be a percentage of the amount of your insurance as follows:

Age of Employee	Amount of Insurance as a Percentage of Amount Prior to Attaining Age 65*
65-69	65%
70-74	50%
75 and over	25%

*AD&D coverage stops at age 70.

Supplemental Life Insurance

Rates for Supplemental Life Insurance are based on your age and the amount of additional coverage you desire. Use the chart and example on page 9 to calculate your monthly rate. Your premium is an after-tax deduction.

FLEXIBLE SPENDING ACCOUNT OPTIONS

The University offers Health Care and Dependent Care Flexible Spending Accounts (FSA) to help you pay your health care and dependent care expenses. You can participate in one or both accounts. The accounts allow you to set aside pre-tax dollars to pay for eligible medical, dental, vision, and dependent care expenses. Each pay period, you make contributions to your flexible spending account through convenient payroll deduction. You don't pay taxes on the amount you contribute, so your federal and state income taxes may be reduced.

How Much Can I Contribute?

	Healthcare FSA	Dependent Care FSA
Annual Minimum	\$120 per year	\$120 per year
Annual Maximum	\$5,000 per year	\$5,000 per year (per family)

- Estimate your eligible out of pocket health care expenses for calendar year 2010
 - Common expenses are office co-payments, prescription drug co-payments, deductions, orthodontia, over the counter medication and vision care. As a general rule, any health care expense you could deduct on your federal income tax return is eligible for reimbursement. See <http://hr.nd.edu/benefits/flex.shtml> for a partial list of eligible expenses.
- Estimate your eligible dependent care expenses for calendar year 2010
 - Work related care for your eligible dependent(s) provided by eligible caregiver
 - Eligible dependents are your children under the age of 13 or a dependent of any age who lives with you and is physically or mentally incapable of self care
 - Note: Nursery school, kindergarten, and overnight camps are examples of expenses not covered. A complete description of eligible expenses is found at www.irs.gov in IRS publication #503, Child and Dependent Care Expenses".
- Health Care and Dependent Care Accounts are separate accounts and by law can only be used for each account's eligible expenses

How Am I Reimbursed for Expenses?

- If you participate in the Health Care FSA and have medical coverage through the University, Meritain will automatically process your medical plan co-payments and/or co-insurances through the FSA account to reimburse you for eligible out-of-pocket expenses.
- For all other health care expenses, including prescription drug co-payments, and dependent care expenses, you will need to submit a claim form with appropriate documentation such as an itemized bill or receipt to Meritain.

What If I Have Money Left Over at the End of the Year?

- If you have money remaining in your Health Care or Dependent Care FSA Account after December 31, 2010, eligible claims with a date of service prior to March 15, 2011 will still be reimbursed from your 2010 accounts as long as they are submitted by March 31, 2011.

Dependent Care Reimbursement for Terminated Employees

If you are no longer working at the University, you may continue to submit eligible expenses to your Dependent Care Flexible Spending Account until your balance is depleted. Please note you must be working or actively seeking employment in order to seek reimbursement.

Election Changes with Qualifying Life Event

- Once your FSA elections are made during the Open Enrollment period, you will not be able to make a change to your elections until the next Open Enrollment period unless you have a qualifying life event. See http://hr.nd.edu/benefits/index_changes.shtml for more details.
- Dependent Care Expenses incurred during a medical leave of absence are not eligible for reimbursement due to IRS regulations. If this occurs, you should consider changing your Dependent Care FSA election for the remainder of the year.

Important Tax Considerations

- When you pay expenses through the Health Care FSA, you lose the opportunity to take a federal income tax deduction if those expenses would be above 7.5% of your adjusted gross income.
- If you participate in the Dependent Care FSA, you will not be able to take the dependent care tax credit for any expense paid through the FSA.
- For more information, consult your tax advisor.

Orthodontia Reimbursement

You may be reimbursed through your Health Care Flexible Spending Account for the entire amount of orthodontia expenses up front if the doctor requires the payment.

Pre-Tax Savings Example

Annual Savings Example*	With a FSA	Without a FSA
If your annual income is	\$28,000	\$28,000
Out of pocket medical expenses pre-tax	\$1,500	-0-
Your taxable income becomes	\$26,500	\$28,000
Federal, FICA & State taxes	\$8,440	\$8,918
Out of pocket medical expenses after tax	-0-	\$1,500
Income after medical expenses	\$18,060	\$17,582
Taxes Saved	\$478	

FREQUENTLY ASKED QUESTIONS

Medical Plans

Question	Answer
What does "in-network mean?"	An in-network provider is a physician, facility, or other provider that has agreed to supply covered services to their members at a reduced or negotiated rate.
What does "out-of-network" mean?	An out-of-network provider is a physician, facility, or other provider that has not contracted with the selected medical plan and may charge participants higher or non-negotiated rates.

Meritain PPO - Anchor Hospital St. Joseph Regional Medical Center

Question	Answer
How do I contact Meritain?	Meritain has established a dedicated toll free number for faculty and staff of Notre Dame. Customer Service Representatives are available Monday-Friday, 8:00 a.m.-5:00 p.m. (EST) at 1-888-668-6855. Information regarding claims can also be obtained on their website at www.meritain.com .
What is Utilization Management?	Utilization Management is the department that handles prior authorizations and pre-certifications
Who should I contact for Utilization Management?	Meritain also handles utilization management. The toll free number for utilization management is 1-800-242-1199. This number is also listed on your identification card.
When should I contact Utilization Management?	Utilization Management should be contacted before you or a covered family member is admitted to the hospital. In the case of a life-threatening emergency, Meritain must be notified within 48 hours or the first business day following hospital admission.
What networks are associated with the Preferred Provider Organization Plan?	The Preferred Provider Organization (PPO) will be utilizing three networks. The local network is Select Health Network, the national network is Beech Street Network, and the Midwest behavioral health network is New Avenues.

HIPAA NOTICE OF AVAILABILITY

The Privacy Rule under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to remind covered participants of the availability of the Privacy Notice and how they can obtain it.

The Notice of Privacy Practices for the University of Notre Dame's Flex Plan describes the uses and disclosures of your protected health information and your rights regarding them.

A copy of The Notice of Privacy Practices for the University of Notre Dame's Flex Plan can be obtained by:

- Visiting the Human Resources website at: <http://hr.nd.edu/benefits/privacypractices.shtml>
- Contacting the askHR call center at: 574-631-5900
- Email: askhr@nd.edu
- Visiting Shared Services in the Office of Human Resources, Grace Hall, Second Floor

How do I locate a provider in the Select Health Network?	You can log onto their website at www.selecthealthnetwork.com or use a paper directory, which is available in the Office of Human Resources.
How do I locate a provider in the Beech Street Network?	Beech Street can be contacted by phone at 1-800-432-1776 or online at www.beechstreet.com . You can use this contact information to verify network participation or to nominate doctors who currently are not affiliated.
How do I locate a mental health provider?	New Avenues (Midwest Behavioral Health Network) can be contacted by phone at 1-800-223-6246 or online at www.newavenuesonline.com .

Meritain CHA HMO - Anchor Hospital Memorial Hospital

Question	Answer
How do I contact Meritain?	Meritain has a dedicated toll free number for faculty and staff of Notre Dame. This number is 1-888-668-6855. Customer Service Representatives are available Monday-Friday, 8:00 a.m. - 5:00 p.m. EST. Information regarding claims can also be obtained on their website at www.meritain.com .
What is Utilization Management?	Utilization Management is the department that handles prior authorizations and pre-certifications
Who should I contact for Utilization Management?	Meritain also handles utilization management. The toll free number for utilization management is 1-800-242-1199. This number is also listed on your identification card.
When should I contact Utilization Management?	Utilization Management should be contacted before you or a covered family member is admitted to the hospital. In the case of a life-threatening emergency, Meritain must be notified within 48 hours or the first business day following hospital admission.
What network does the Meritain CHA HMO use?	Meritain CHA HMO accesses Community Health Alliance (CHA) for the in-network benefit.
How do I locate a provider in the Community Health Alliance Network?	You can visit their website at www.chanetwork.com or call 1-574-284-1025 or 1-888-689-2242. A paper directory is available in the Office of Human Resources.
What health professionals require a \$20 co-payment?	Family and General Practitioners, Internists, Pediatricians and OB-GYN physicians.
When is a \$30 co-payment required?	When you visit a specialist physician in the network there is a \$30 copayment.
What hospitals are considered in-network?	The in-network hospitals include Memorial, Elkhart General Hospital and Lakeland.
Do I have to notify the insurance company if my child is a full time student?	Yes, If you are enrolling a dependent age 19-25, you must verify full-time student status on the open enrollment application.

Meritain Select HMO - Anchor Hospital St. Joseph Regional Medical Center

Question	Answer
How do I contact Meritain?	Meritain has a dedicated toll free number for faculty and staff of Notre Dame. This number is 1-888-668-6855. Customer Service Representatives are available Monday-Friday, 8:00 a.m. - 5:00 p.m. EST. Information regarding claims can also be obtained on their website at www.meritain.com .
What network does Meritain Select HMO use?	Meritain Select HMO uses the Select network and the Midwest Behavioral Health Network is New Avenues.
How do I locate a provider in the Select Medical Management network?	You can log onto their website at www.selecthealthnetwork.com or use a paper directory, which is available in the Office of Human Resources.
How do I locate a mental health provider?	New Avenues (Midwest Behavioral Health Network) can be contacted by phone at 1-800-223-6246 or online at www.newavenuesonline.com .
Is there any benefit if I see a provider or facility not in the network?	This HMO is an in-network plan only. There is no coverage if you see a provider or facility that is not in the network.
What health professionals require a \$20 co-payment?	Family and General Practitioners, Internists, Pediatricians and Ob-Gyn physicians.
When is a \$30 co-payment required?	When you visit a specialist physician in the network, there is a \$30 co-payment.
What hospitals are considered in-network?	The in-network hospitals include St. Joseph Regional Medical Center, Goshen, LaPorte & Lakeland.
Do I have to notify the insurance company if my child is a full time student?	Yes, if you are enrolling a dependent age 19-25, you must verify full-time student status on the open enrollment application.

Prescription Drug - Medco

Question	Answer
Which pharmacies can I use?	You can log onto www.medco.com to find out whether a particular pharmacy is in the network.
How will I get started using the mail service pharmacy?	<p>If you are using the mail service for the first time, requesting a new prescription for home delivery is simple whether you are ordering my mail, fax, or online. Just follow these steps:</p> <p>By Mail:</p> <p>Step 1: Ask your doctor to write a new prescription for up to a 90-day supply, plus refills (if appropriate) for up to 1 year.</p> <p>Step 2: Mail the new prescription(s), along with the "Ordering Medications" form and the appropriate co-payment, to Medco in the return envelope.</p>

Question	Answer
	<p>By Fax:</p> <p>Step 1: Ask your doctor to write a new prescription for up to a 90-day supply, plus refills (if appropriate) for up to 1 year. Give your doctor your member ID number, which is on your prescription ID card.</p> <p>Step 2: Ask your doctor to call 1-888-EASYRX1 (1-888-327-9791). Your doctor will receive directions for faxing your prescription to Medco, and you will be billed later.</p> <p>Online:</p> <p>You can request new prescriptions online by visiting www.medco.com.</p> <p>Step 1: If you haven't already done so, take a few moments to register with Medco, making sure you let them know that you are a Medco plan member when prompted. Once you are registered, all you need to do when you return is log in using the email address and password you created.</p> <p>Your medication will be delivered to your home within 7 to 11 days after you mail your order. Orders placed via the internet, telephone, or fax may be received even faster. Standard shipping is free.</p>

Dental - Delta Dental Premier

Question	Answer
What is Delta Dental Premier?	Delta Dental Premier is Delta Dental's carefully managed national fee-for-service program. Although you can go to any licensed dentist anywhere, your out-of-pocket costs are likely to be lower if you go to a Delta Dental Premier dentist. More than 121,000 dentists throughout the United States and its territories participate in this program - about three out of every four practicing dentists nationwide.
What are the advantages of choosing a Delta Dental Premier dentist?	When you go to a Premier dentist for covered services, Delta Dental will pay that dentist directly based on the dentist's submitted fee or the local Delta Dental's Maximum Approved Fee, whichever is less. If the Maximum Approved Fee is lower than the dentist's submitted fee, the dentist cannot charge you the difference. This means you will be responsible only for your copayments and deductible, if any, when you go to a Premier dentist for covered services. Premier dentists will also fill out and file your claim forms, which means fewer hassles for you.
How can I find a participating dentist?	To get the names of participating dentists near you, you can call our Customer Service department, toll-free, at (800) 524-0149. Our DASI (Delta's Automated Service Inquiry) system is available 24 hours a day, seven days a week, and can provide you with the names of PPO dentists near you. You can also check our Web site at www.consumertoolkit.com .

Do I need to tell my dentist my coverage has changed?	If this is a new plan for you, yes. It would be helpful if you told your dentist that you have Delta Dental PPO (Point-of-Service) Preferred or Delta Dental Premier coverage.
What if I go to a nonparticipating dentist?	If you go to a dentist who does not participate in Delta Dental PPO Preferred or Premier, you will still be covered, but you may have to pay more. Delta Dental will pay you directly for covered services based on the dentist's submitted fee or the local Delta Dental's nonparticipating dentist fee, whichever is less. You will be responsible for paying the dentist whatever he or she charges. You may also have to submit your own claims.
Do I need an ID card to receive care?	No. Your dentist can verify your eligibility for coverage 24 hours a day, seven days a week, by checking our online Dental Office Toolkit or by calling our DASI (Delta's Automated Service Inquiry) system.

Dental - Delta Dental PPO Point-of-Service POS

What is Delta Dental PPO POS Preferred Plan?	<p>Delta Dental PPO (Point-of-Service) is Delta Dental's national preferred provider organization program that gives you access to two of the nation's largest networks of participating dentists – our Delta Dental PPO network and our Delta Dental Premier network. Although you can go to any licensed dentist anywhere, your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of these networks.</p> <p>More than 60,000 dentists throughout the United States and its territories participate in Delta Dental PPO, and over 121,000 dentists nationwide participate in Delta Dental Premier.</p>
What are the advantages of choosing a Delta Dental PPO dentist?	You will receive the highest level of coverage for some services when you go to a PPO dentist. In addition, Delta Dental will pay the PPO dentist directly for covered services based on his or her submitted fee or the amount in the local Delta Dental's PPO dentist schedule, whichever is less. If the PPO dentist schedule amount is lower than the dentist's submitted fee, the dentist cannot charge you the difference. This means you will be responsible only for your copayments and deductible, if any, when you go to a PPO dentist for covered services. PPO dentists will also fill out and file your claim forms, which means fewer hassles for you.
What are the advantages of choosing a Delta Dental Premier dentist in the PPO plan?	<p>Although you will receive a lower level of coverage for some services when you go to a Premier dentist, Delta Dental will pay the Premier dentist directly for covered services based on his or her submitted fee or the local Delta Dental's Maximum Approved Fee, whichever is less. If the Maximum Approved Fee is lower than the dentist's submitted fee, the dentist cannot charge you the difference.</p> <p>As with PPO dentists, this means you will be responsible only for your copayments and deductible, if any, when you go to a Premier dentist for covered services. And, like PPO dentists, Premier dentists will fill out and file your claim forms for you.</p>

How can I find a participating dentist?	To get the names of participating dentists near you, you can call our Customer Service department, toll-free, at (800) 524-0149. Our DASI (Delta's Automated Service Inquiry) system is available 24 hours a day, seven days a week, and can provide you with the names of PPO dentists near you. You can also check our Web site at www.consumertoolkit.com .
What if I go to a nonparticipating dentist?	If you go to a dentist who does not participate in Delta Dental PPO Preferred or Premier, you will still be covered, but you may have to pay more. We will pay you directly for covered services based on the dentist's submitted fee or the local Delta Dental's nonparticipating dentist fee, whichever is less. You will be responsible for paying the dentist whatever he or she charges. You may also have to submit your own claims.
Do I need to tell my dentist my coverage has changed?	If this is a new plan for you, yes. It would be helpful if you told your dentist that you have Delta Dental PPO (Point-of-Service) Preferred or Delta Dental Premier coverage.
Do I need an ID card to receive care?	No. Your dentist can verify your eligibility for coverage 24 hours a day, seven days a week, by checking our online Dental Office Toolkit or by calling our DASI (Delta's Automated Service Inquiry) system.

Vision - Eye Med

Question	Answer
Do I need to obtain a claim form prior to receiving vision services?	No, when visiting an in-network EyeMed provider, you do not need to request a claim form. Simply present your EyeMed Member ID card at the time of your appointment. Taking advantage of your EyeMed benefits is easy and convenient.
I have an eye care professional that I already visit on a regular basis. How can I find out if he/she is an EyeMed provider?	To find out whether or not your current eye care professional is an EyeMed provider, do one of the following: 1) contact your eye care professional, 2) use EyeMed's online provider locator at www.enrollwiththeyemed.com , or 3) call 1-877-226-1115 and use the automated phone system to inquire about EyeMed providers.

Life Insurance - Minnesota Life

Question	Answer
When do I need to complete an Evidence of Insurability (EOI) form?	When you are electing a life insurance increase of more than 1 x salary, when you request a life insurance increase more than \$100,000, when you elect supplemental or dependent life insurance for the first time, are increasing dependent life insurance coverage, or after previously canceling coverage.
What amount of life insurance should I carry for my family?	Most financial experts suggest that a family carry life insurance equal to five to seven times their annual household income, plus an additional one-time annual salary for each child under 18.

Flexible Spending Accounts

Question	Answer
How do I get reimbursed?	Eligible expenses may be submitted at any time during the plan year by completing a claim form and attaching photocopies of your out-of-pocket expenses. These items can be sent to Meritain by fax at 1-888-837-3725 or by mail to P.O. Box 3011, Lansing, MI 48909
Who do I contact for questions?	You can contact the Meritain Customer Service Center by phone at 1-866-448-1696.
What happens to any unused balances?	Unused balances within your FSA at plan year end will be granted a 2-1/2 month grace period, according to IRS regulations. If services are not rendered by March 15, 2011 and submitted for reimbursement by March 31, 2011 then the 2010 unused balance will be forfeited, according to IRS regulations.
What is the FSA plan year?	The FSA plan year is from January 1, 2010 to December 31, 2010.
What is the deadline for filing 2010 claims?	Claims may be filed until March 31, 2010 for services rendered by March 15, 2011.

Miscellaneous

Question	Answer
Is there a website where I can review the benefit options?	Yes, visit the Open Enrollment website at http://hr.nd.edu/openenroll to review the benefit options.

OPEN ENROLLMENT LIAISONS

Open Enrollment Liaisons have been designated across campus to provide information regarding the Open Enrollment process. You may contact or visit one of the Liaisons listed below to receive information on the 2010 benefit program. From the Office of Human Resources, **thank you** to the Liaisons for supporting the Open Enrollment Process.

Department/College	Liaison
Alumni Association/Eck Center	Sherry Veith
Architecture	Brian Flaherty
Arts & Letters	Linda Brady
Athletics	Jody Sadler
Athletics	Jenny Borg
Brownson Hall	Andrea Johnson
Coleman/Morse	Mary Olen and Sue Penrod
College of Business	Doug Kroll
College of Science	Elizabeth Hasse
Engineering	
Facilities Operations	Sharon Hawkins and Matthew Blazejewski
Flanner Hall	Sherry Veith
Food Services	Sharon Hawkins and Matthew Blazejewski
Hurley	Patti Strauch
Hesburgh Library	Michelle Stenberg
Law School	Cathy Roemer
Main Building	Gene Pilawski
McKenna Hall	Lori Morgan
Morris Inn	Susan Tuttle
Morris Inn	Diane Navarre
OIT	Giovanna Edwards
Student Activities	Carol Taylor
Security	Don Nemeth
University Health Center	Connie Morrow