UNIVERSITY OF NOTRE DAME

MEDICAL/DENTAL/VISION PLAN SUMMARY 2004

MEDICAL/DENTAL/VISION PLAN SUMMARY - 2004

To help you make informed decisions about your insurance election, the University has prepared this 2004 Medical/Dental/Vision Plan Summary.

You are responsible for notifying the Office of Human Resources within 31 days of a status change, 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

Advantage Health Plan (HMO) Member Service • Eligibility & Claim Inquiries	www.advantageplan.com	**1-800-553-8933**
North American (NAA) PPO: • Eligibility, benefit coverage, pre-certification, claim questions	www.nahp.com	**1-888-668-6855**
• Select Health Network (Local Network)	www.selecthealthnetwork.com	**1-888-668-6855**
• Beech Street (National Network)	www.beechstreet.com	**1-800-432-1776**
• New Avenues Midwest Behavioral Health Network (mental health provider)	www.newavenuesonline.com	**1-800-223-6246**
North American (NAA) Health Plan: • Eligibility, benefit coverage, pre-certification, claim questions	www.nahp.com	**1-888-668-6855**
• Community Health Alliance (CHA) Network	www.chanetwork.com	**1-888-689-2242 or 1-574-284-1820**
MedcoHealth	www.medcohealth.com	**1-800-711-0917**
DeltaPremier USA	www.deltadental.com	**1-800-524-0149**
HRI Dental Health Options Customer Service	www.hri-dho.com	**1-888-455-5141**
EyeMed	www.eyemedvisioncare.com www.enrollwitheyemed.com	**1-866-939-3633**

PLAN COVERAGE	NORTH AMERICAN PPO	ADVANTAGE	NORTH AMERICAN HEALTH PLAN
General Information	Under North American (NAA) PPO, you must call North American 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 or www.beechstreet.com. 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**.	Services are provided by physicians associated with the HMO. To be eligible, a person must reside or work in the HMO's service area. The HMO Primary Care Physician directs and approves all medical care. Lists of Network physicians and hospitals are available at www.advantageplan.com. Each family member may select a different Primary Care Physician. Midwest Behavioral network Case manager directs and approves all mental health services.	Services are provided by physicians associated with the Health Plan. To be eligible, a person (and dependents) must reside or work in the Health Plan's service area. The Health Plan does not require a referral for Specialist Care. Lists of Network physicians and hospitals are available at www.chanetwork.com or by calling (574) 284-1820 or 1-888-689-2242.
Monthly Premiums *(full-time Faculty, Administrators and Staff)*	Individual coverage $ 30.00 Family coverage $117.00	Individual coverage $ 23.00 Family coverage $ 94.00	Individual coverage $ 28.00 Family coverage $108.00
Deductibles (Cross accumulates between in-network and out-of-network)	Individual / Family **In-Network** $400 / $800 **Out-of-Network** $800 / $1600	None	None
Co-insurance (Your share of eligible expenses)	**In-Network:** After your meet your annual deductible, the plan pays 85% of eligible charges and you pay the remaining 15%.	None	None

	Out-of-Network: 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.		
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Out-of-pocket limits (Note: Once the out-of-pocket limit is met on an annual basis, the plan pays 100%. No one family member may meet this limit for the whole family.) Includes the annual deductible. (Cross accumulates between in-network and out-of-network).	Individual / Family In-Network: $1,000 / $2,500 Out-of-Network: $2,000 / $4,500	Not Applicable	Not Applicable
Physician Office Visits *(Co-payments)*	**In-Network:** $15 physician co-payment per office visit (after the co-payment is made, the plan pays 100%). This $15.00 co-payment is still required even after deductible is met. **Out-of-Network:** 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.	$15 co-payment per office visit. (After co-payment is made, the plan pays 100%.)	**Primary Care Physician** (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.) $15 co-payment per office visit. (After co-payment is made, the plan pays 100%.) **Specialist Physician** $25 co-payment per office visit. (After co-payment is made, the plan pays 100%)
Physician Hospital Visits	**In-Network:** 85% **Out-of-Network:** 65% After annual deductible is met.	No Charge	No Charge
Health Education	Not Applicable	Not Applicable	Not Applicable

Ambulance	**Network:** 85% **Out-of-Network:** 65% After annual deductible is met.	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.
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Anesthesiology, Cardiac and Intensive Care	**Network:** 85% **Out-of-Network:** 65% After annual deductible is met.	No Charge	No Charge
Cardiac Rehabilitation	**Network:** 85% **Out-of-Network:** 65% After annual deductible is met.	$15 co-payment per office visit. 60 visits per each distinct condition or episode.	$15 co-payment per office visit. 36 visits per year.
Children Eligibility *(Due to age)*	Children are eligible until they reach age 23 as long as they remain unmarried and eligible on an employees' tax return. Coverage ends at December 31 of calendar year in which they turn 23.	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), 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 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.
Coordination of Benefits (C.O.B.)	NAA 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 and day your birthday falls during the year is <u>before</u> your spouse's birthday, NAA will be primary and pay benefits first for your dependents.	ADVANTAGE is always 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 and day your birthday falls during the year is <u>before</u> your spouse's birthday, ADVANTAGE will be primary and pay benefits first for your	North American 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 and day your birthday falls during the year is <u>before</u> your spouse's birthday, NAA will be primary and pay benefits first for your dependents.

	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.	dependents. ADVANTAGE would coordinate benefits with the primary Carrier. Applicable co-payments would still apply.	If another plan is primary, North American Health Plan will consider the remaining eligible charges. North American Health Plan would coordinate for any service within their network.
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Diabetic Supplies Part of the Pharmacy Benefit. See page12.			
Durable Medical Equipment	**<u>In-Network</u>** After deductible, plan pays 85% of eligible charges up to annual maximum. **<u>Out-of-Network</u>** After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges. Annual maximum of $15,000 per person / per year.	Covered in full; $2,500 maximum per calendar year.	Covered in full.
Emergency Services *(Out-of-Area/Out-of-State)*	You are not required to contact NAA 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 network provider. If the medical emergency turns into an inpatient hospital admission, the physician or the employee should contact NAA within 48 hours to have the stay pre-certified.	If you are facing a medical emergency and your medical condition is dangerous or life threatening go to the nearest medical facility for treatment, whether you are in the ADVANTAGE service area or out of the area. Call or make certain that your Primary Care Physician is contacted as soon as possible, in any case within 48 hours. $75 co-payment for Emergency Room Routine medical care and non-emergency care received out of town is not covered.	Out-of-Service Area, seek emergency services and notify North American Health Plan within 48 hours to assist with the processing of the claim. Should the employee have any questions, they can reach North American Health Plan at 1-888-668-6855. $100 co-payment for Emergency Room Routine medical care and non-emergency care received out of town is not covered.
Emergency Services	**<u>Network:</u>** 85%	$75 co-payment for Emergency Room	$100 co-payment for Emergency Room

(In-Area)	**Out-of-Network:** 65% After annual deductible is met. **Urgent Care** $50 co-payment for services provided at South Bend Clinic Immediate Care Center.	(waived if patient is admitted). **Urgent Care** $25 co-payment for Urgent Care services provided.	(waived if patient is admitted). **Urgent Care** $40 co-payment for Urgent Care Facility at MedPoint
PLAN COVERAGE	**NORTH AMERICAN PPO**	**ADVANTAGE**	**NORTH AMERICAN HEALTH PLAN**
Fertility Testing and Counseling	**Network:** 85% **Out-of-Network:** 65% After annual deductible is met. 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.	$15 co-payment per office visit for Out-Patient charges or $250 hospital co-payment for In-Patient stays or $100 co-payment for out-patient surgery. Subject to $2,500 lifetime maximum. 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.	$15 co-payment per office visit for Out-Patient charges from a PCP or $250 hospital deductible for In-Patient. Subject to $2,500 lifetime maximum. 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.
Home Health Care	**Network:** 85% **Out-of-Network:** 65% 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.	No charge. There may be some limitations.	100% after $15 co-payment per visit. Limit of 60 visits per Calendar Year.
Hospital Room & Board	**Network:** 85% **Out-of-Network:** 65% After annual deductible is met.	A $250 hospital co-payment is required per person per hospital admission. Maximum of $500 per person/$1,000 per family for in-patient services per plan year (the $500 per person charge is two hospital admissions; the $1,000 is four hospital admissions).	A $250 hospital co-payment is required per person per hospital admission. Maximum of $500 per person/$1,000 per family for in-patient services (the $500 per person charge is two hospital admissions; the $1,000 is four hospital admissions).

Human Organ Transplants	NAA 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.	Human organ and tissue transplant services for both the recipient and the donor are covered when the recipient is a covered person. In-patient hospital co-payment applies. $10,000 benefit for transportation and lodging.	Liver, heart, kidney, cornea, bone marrow--are treated the same as hospital inpatient expenses.
PLAN COVERAGE	**NORTH AMERICAN PPO**	**ADVANTAGE**	**NORTH AMERICAN HEALTH PLAN**
Hospitals	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 • St. Joseph Community Hospital, Mishawaka, IN; • St. Joseph Hospital Regional Medical Center, Plymouth, IN; • St. Joseph's Regional Medical Center, South Bend, IN; • South Haven Community Hospital, South Haven, MI	• Community Hospital of Bremen, Bremen, IN • St Joseph's Regional Medical Center, Inc., Plymouth Campus • Saint Joseph's Medical Center, Inc., South Bend Campus • Saint Joseph's Community Hospital of Mishawaka, Inc. • (See directory or web page for a complete listing.)	• 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; • Memorial Hospital, South Bend, IN; • 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; • (See directory or web page for a complete listing.)
Laboratory & X-Ray (Billed by a radiologist, pathologist or hospital)	**Network:** 85% **Out-of-Network:** 65% After annual deductible is met.	No Charge	No Charge

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Maternity	**<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 $15 co-payment may not be required at each office visit. Subject to annual deductible and 85/15% coinsurance. Memorial Hospital Mother and Child Care Center and neo-natal nursery are included as in-network services. Baby Steps is a program offered by NAA that offer case management to High-risk pregnancies. **<u>Out-of-Network:</u>** Pre-natal and post-natal office visits and delivery---subject to annual deductible and 65% /35% coinsurance. ***Baby needs to be enrolled within 31 days of birth.***	100% after $15 co-payment per office visit. Delivery fee is the same as regular hospitalization. Delivery Fee: $250 hospital co-payment per person per admission. One hospitalization co-pay applies for mother and child providing mother and child are discharged at the same time. ***Baby needs to be enrolled within 31 days of birth.***	100% after $15 co-payment per office visit. Delivery fee: $250 hospital co-payment per person per admission. ***Baby needs to be enrolled within 31 days of birth.***

Mental Health Services *(In-patient)*	**Network:** 85% **Out-of-Network:** 65% After annual deductible is met for physician (M.D., Ph.D. and Licensed Clinical Social Worker) services. Limited to 60 days a year. (Less in-patient alcoholism/drug abuse days used).	100% after $250 co-payment per admission. Pre-authorization by Midwest Behavioral Health Network Case Manager required to determine "medical necessity" and duration.	100% after $250 co-payment per admission. Limited to 60 days per member per year. Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your therapist.
PLAN COVERAGE	**NORTH AMERICAN PPO**	**ADVANTAGE**	**NORTH AMERICAN HEALTH PLAN**
Mental Health Services *(Out-patient)*	**In-Network:** 85% **Out-of-Network**: 65% 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 $15 co-payment. Limited to 50 visits per year. (Less in-patient alcoholism/drug abuse visits used).	Out-patient visits as determined medically appropriate by an Midwest Behavioral Health Network Case Manager for detoxification, short term evaluation and/or crisis intervention. 100% after $15 co-payment per office visit. Limited to 60 visits per distinct condition or episode.	Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional. Covers short-term crisis and acute symptoms or impairment stabilization. 100% after $25 co-payment per office visit. Limited to 20 visits per contract year per member when medically necessary.
Occupational Therapy	**In-Network:** $15 co-payment per visit. **Out-of-Network:** 65% After annual deductible is met.	In-patient short-term rehabilitation covered, hospital co-payment applies. Out-patient short-term rehabilitation covered for up to 60 visits, with a $15 co-payment per office visit. Otherwise, not covered.	100% after $15 co-payment per office visit for up to 20 outpatient visits. Inpatient short-term rehabilitation covered for 60 consecutive days. Long-term rehabilitation is **NOT** covered.
Physical Therapy	**In-Network:** $15 co-payment per visit. **Out-of-Network:** 65% After annual deductible is met.	100% after a $15 co-payment per office visit for up to 60 out-patient visits. In-patient short-term rehabilitation covered for 60 consecutive days with applicable hospital co-payments. Long-term rehabilitation is **NOT** covered.	100% after $15 co-payment per office visit for up to 20 outpatient visits. Inpatient short-term rehabilitation covered for 60 consecutive days. Long-term rehabilitation is **NOT** covered.

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Orthotic Appliances *(such as braces or splints)*	**<u>In-Network:</u>** After deductible, plan pays 85% of eligible charges up to annual maximum. **<u>Out-of-Network:</u>** After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges. Annual maximum of $10,000 per person / per year.	Covered in full; up to annual $2500 maximum per calendar year. (Some limitations and exclusions apply, such as foot Orthotics.)	Covered in full. (Some limitations and exclusions apply.)
Preventive Care - *Adults*	**Participants age 18 and over**	**No age limit**	**No age limit**
• Physical Exam	• **<u>In-Network</u>**: Every year after age 40. $15 physician co-payment. **<u>Out-of-Network</u>**: Not covered.	• 100% after $15 co-payment per office visit.	• 100% after $15 co-payment per office visit
• Well Woman Care (including Pap test) (also includes teenage females)	• Once per year	• 100% after $15 co-payment per office visit	• 100% after $15 co-payment per office visit
• Mammogram	• Baseline at age 35; annually after age 40.	• 100% after $15 co-payment per office visit	• 100%
• Blood Screening (plus blood pressure/height and weight)	• One per year	• 100% after $15 co-payment per office visit	• 100% after $15 co-payment per office visit
• Sigmoidoscopy	• One per year after age 50.	• 100% after $15 co-payment per office visit	• 100% after $15 co-payment per office visit
• Occult blood	• One per year after age 40.	• 100% after $15 co-payment per office visit	• 100% after $15 co-payment per office visit
• Prostate-Specific Antigen (PSA)	• One per year after age 50.	• 100% after $15 co-payment per office visit	• 100% after $15 co-payment per office visit
• Eligible immunizations: DPT, MM, Tuberculin skin test and annual flu shot.	• 18 years of age and older - only applicable to eligible immunizations.	• 100% after $15 co-payment per office visit	• 100% after $15 co-payment per office visit Services must be provided by a PCP (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.)

Preventive Care - ***Children*** • Periodic well care checkups • Well-baby care • Immunizations/inoculations *(for participants up to age 19 for state mandated immunizations)*	**For participants who are 6 years old or younger** **In-Network:** $15 physician co-payment per office visit **Out-of-Network**: Subject to annual deductible and 65% coinsurance. • Mandated immunizations are covered at any age.	**No age limit** • 100% after $15 co-payment per office visit • 100% after $15 co-payment per office visit • 100% after $15 co-payment per office visit	**No age limit** • 100% after $15 co-payment per office visit • 100% after $15 co-payment per office visit • 100% after $15 co-payment per office visit Services must be provided by a PCP (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.)
PLAN COVERAGE	**NORTH AMERICAN PPO**	**ADVANTAGE**	**NORTH AMERICAN HEALTH PLAN**
Prosthesis	**In-Network:** After deductible, plan pays 85% of eligible charges up to annual maximum. **Out-of-Network:** After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges. Annual maximum of $20,000 per person / per year.	Covered in full (excluding artificial limbs). Limit up to annual maximum of $2,500.	Covered in full.
Skilled Nursing Facility	**In-Network:** 85% **Out-of-Network:** 65% After annual deductible is met if medically necessary. No custodial care.	No charge for up to 100 days per Medicare guidelines and following a hospital stay. Custodial care is not covered.	No charge for up to 60 days per calendar year. There may be some limitations. No custodial care.

Speech Therapy	**<u>In-Network</u>:** $15 co-payment per visit. **<u>Out-of-Network</u>:** 65%, after annual deductible is met.	In-patient short-term rehabilitation covered, hospital co-payment applies. Out-patient short-term rehabilitation covered for up to 60 visits, with a $15 co-payment per office visit. Otherwise, not covered.	100% after $15 co-payment per office visit for up to 20 outpatient visits. Inpatient short-term rehabilitation covered for 60 consecutive days. Long-term rehabilitation is **NOT** covered.
Substance Abuse Services *(In-patient)* *Cross-accumulation with mental health.*	**<u>In-Network</u>:** 85% **<u>Out-of-Network</u>:** 65% After annual deductible is met and if confined in an approved facility. Limit of 60 days per year.	Pre-authorization by Midwest Behavioral Health Network Case Manager required to determine "a medical necessity" and duration. 100% of covered services for detoxification; limited to two detoxifications per lifetime. 100% after $250 co-payment per admission. Limited to a maximum of 14 days per calendar year.	Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional; covers short-term crisis and acute symptoms or impairment stabilization. 100% after $250 co-payment per admission; limited to 10 days per member per calendar year.
PLAN COVERAGE	**NORTH AMERICAN PPO**	**ADVANTAGE**	**NORTH AMERICAN HEALTH PLAN**
Substance Abuse Services *(Out-patient)* *Cross-accumulation with mental health.*	**<u>In-Network</u>:** 85% **<u>Out-of-Network</u>:** 65% 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 $15 co-payment. Limited to 50 visits per year. (Less in-patient alcoholism/drug abuse visits used).	Out-Patient visits as determined medically appropriate by a Midwest Behavioral Health Network Case Manager for detoxification, short-term evaluation, and/or crisis intervention. $25 co-payment per visit. Limited to 20 visits per member per year. ($25 co-payment waived for group therapy.)	Covers short-term crisis and acute symptoms or impairment stabilization. 100% after $25 co-payment per office visit. Limited to 20 visits per contract year per member when medically necessary.
Surgery / In-patient	**<u>Network:</u>** 85% **<u>Out-of-Network:</u>** 65% After annual deductible is met.	No charge (hospital co-payment applies).	No charge (hospital co-payment applies).
Surgery / Out-patient (office)	**<u>In-Network:</u>** 85% **<u>Out-of-Network:</u>** 65% After annual deductible is met. Services are not considered the same as a	100% after $100 co-payment per procedure for outpatient surgery. Office visit co-payment applies for minor surgery in physician's office.	100% after $100 co-payment per procedure.

	routine office visit and do not qualify for payment at 100% after a $15 co-payment.		
TMJ (Temporomandibular Joint Syndrome)	Limited to office visits, diagnostic services, Orthotic appliances, equilibrations and surgery when medically necessary and ordered by physician. Subject to $1,000 maximum per person per year/$3,000 lifetime maximum.	Not Covered	Not Covered
Voluntary Abortion and/or Sterilization	Not Covered	Not Covered	Not Covered

PHARMACY BENEFIT- WITH ALL MEDICAL PLANS

Program Administrated by Medco Health www.medcohealth.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	Home Delivery Up to a 90-day supply
Generic	$8	$16
Brand formulary	$15	$30
Brand non-formulary	$30	$60

What is a formulary?

Your prescription drug benefit plan includes a formulary, which is a list of drugs that are preferred by your plan. This list includes a wide selection of drugs and is preferred because it offers you choice while helping keep the cost of your prescription drug benefits affordable. Each drug is approved by the Food and drug Administration (FDA) and reviewed by an independent group of doctors and pharmacists for safety and efficiency.

Generic Drugs versus Brand Name 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 from to the brand-name product. The federal Food and Drug Administration regulates the quality, strength and purity of generic 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.

Diabetic Coverage:

With your insulin prescription and co-payment, you may also order a 30-days supply of the following Diabetic Supplies:

- Alcohol Swabs
- Lancets
- Urine/Blood Test Strips & Tapes
- Blood Glucose Testing Monitors
- Insulin Syringes w/wo Needles

If you choose to order supplies separately from your insulin prescription, a separate co-payment will be applied.

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.

Please note: Faculty, administrators, or staff members that reside in Wisconsin and Vermont will be covered under a separate plan (with the same monthly fee as the regular plan), as all providers in those states are considered out-of-network.

Vision Care	Member Cost	Out-of-Network Allowance	Wisconsin & Vermont
Exam with dilation as Necessary:	$10 co-payment	Up to $35	Up to $35
Standard Plastic Lenses:			
Single Vision	$10 co-payment	Up to $25	Up to $70
Bifocal	$10 co-payment	Up to $40	Up to $70
Trifocal	$10 co-payment	Up to $55	Up to $70
Lenticular	$10 co-payment	Up to $55	Up to $70
Frames:			
Any frame available at provider location	$0 co-payment, $100 allowance for any frame plus 20% off balance over $100	Up to $45	Up to $100
Lens Options:			
UV Coating	$12	N/A	N/A
Tint (Solid and Gradient)	$12	N/A	N/A
Standard Scratch-Resistance	$15	N/A	N/A
Sandard Polycarbonate	$35	N/A	N/A
Standard Progressive-(add-on to Bifocal)	$45	N/A	N/A
Standard Anti-Reflective	$45	N/A	N/A
Other Add-Ons and Services	20% discount	N/A	N/A

Contact Lenses: (Includes fit, follow-up, and materials) Conventional Disposables Medically Necessary	 $0 co-payment, plus 15% discount off balance over $115 $0 co-payment, plus balance over $115 $0 co-payment, plus balance over $250	 Up to $100 Up to $100 Up to $200	 Up to $115 Up to $115 Up to $250
Laser Vision Correction: Lasik or PRK From US Laser Network	15% of retail price or 5% off promotional price	N/A	N/A
Frequency: Examination Frame Lenses or Contact Lenses	 Once every 12 months Once every 12 months Once every 12 months		
Vision Premiums per month	Individual $5.80 Family $13.80		

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

Premier-Plus Secondary Purchase Discount

Vision Care Services	Member Cost
Exam with dilation as Necessary:	$5 off routine exam
Standard Plastic Lenses*: Single Vision Bifocal Trifocal Lenticular *Member cost is $15 higher in AK, CA, HI, OR, WA	 $35 Co-payment $55 Co-Payment $90 Co-Payment $90 Co-Payment
Frames: Any frame available at provider location	45% off retail price up to $130 plus 20% off balance over $130
Lenses Options: UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Sandard Polycarbonate Standard Progressive-(add-on to Bifocal) Standard Anti-Reflective Other Add-Ons and Services	 $12 $12 $15 $35 $45 $45 20% discount

Contact Lenses: Discount applied to materials only) Conventional	15% off retail price
Laser Vision Correction: Lasik or PRK From US Laser Network	15% off retail price – or 5% off promotional price
Frequency: Examination Frame Lenses Contact Lenses	 Unlimited Unlimited Unlimited Unlimited

*The cost for Premium Progressive lenses equals the Basic Progressive lens retail price plus a 20% discount on the balance over this price.

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.

Plan Limitations/Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical an/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment
- 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

DENTAL PLANS

PLAN COVERAGE	DELTAPREMIER USA	HRI DENTAL HEALTH OPTIONS
Network	Offices available in South Bend, Granger, Elkhart, Mishawaka, and more. See www.deltadental.com for details on locations. Delta also offers a benefit for out-of-network services.	Offices available in South Bend, Granger, Elkhart, Mishawaka, and more. See www.hri-dho.com for details on locations.
Deductibles	$50 for basic and major services, limit of $150 per family	None
Diagnostic & Preventive Procedures	100%	100%
Basic Services	50% (after $50 deductible)	50% of Usual & Customary
Major Services	50% (after $50 deductible)	50% of Usual & Customary
Annual Benefit	$1,000 per person per year	$1,000 per person per year
Orthodontics	50% Maximum lifetime benefit of $1,000	50% up to maximum benefit per quarter and $1,000 lifetime
Emergency Care	Same as above	Up to $100
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 dependent turns 25 while in college their coverage would terminate at the end of the month of	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 dependent turns 25 while in college their coverage would terminate at the

	their 25th birthday. If a child loses eligibility their coverage will terminate the end of the calendar month in which they lose eligibility.	end of the month of their 25th birthday. If a child loses eligibility their coverage will terminate the end of the calendar month in which they lose eligibility.
Dental Premiums per month	2004 Individual $12.52 2005 Individual $14.40 Family $52.28 Family $57.44	2004 Individual $27.92 Out of area: Individual $36.68 Family $86.72 Family $110.08

** If enrolling in Delta Dental a 2-year commitment is required.*