



UNIVERSITY OF NOTRE DAME

MEDICAL/DENTAL/VISION PLAN SUMMARY 2006

MEDICAL/DENTAL/VISION PLAN SUMMARY - 2006

To help you make informed decisions about your insurance election, the University has prepared this 2006 Medical/Dental/Vision Plan Summary. This summary is intended to help you learn more about the benefit plans available to you. It does not replace the legal plan documents or contracts for each of the benefit plans and should not, in any way, be considered a legal contract or guarantee of coverage.

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

IMPORTANT CONTACT INFORMATION

Medical	Advantage Health (HMO) Member Service <ul style="list-style-type: none"> Eligibility & Claim Inquiries 	www.advantageplan.com	1-800-553-8933
	Meritain PPO (formally North American): <ul style="list-style-type: none"> Eligibility, benefit coverage, pre-certification, claim questions 	www.meritain.com	1-888-668-6855
	<ul style="list-style-type: none"> Select Health Network (Local Network) 	www.selecthealthnetwork.com	1-888-668-6855
	<ul style="list-style-type: none"> Beech Street (National Network) 	www.beechstreet.com	1-800-432-1776
	<ul style="list-style-type: none"> New Avenues Midwest Behavioral Health Network (mental health provider) 	www.newavenuesonline.com	1-800-223-6246
	Meritain HMO (formally North American): <ul style="list-style-type: none"> Eligibility, benefit coverage, pre-certification, claim questions 	www.meritain.com	1-888-668-6855
	<ul style="list-style-type: none"> Community Health Alliance (CHA) Network 	www.chanetwork.com	1-888-689-2242 or 1-574-284-1820
Prescription	Medco <ul style="list-style-type: none"> Benefit coverage, claim questions 	www.medco.com	1-800-711-0917
Dental	DeltaPremier (PPO)	www.deltadental.com	1-800-524-0149
	Health Resources Inc. (DPO) Customer Service	www.hri-dho.com	1-888-455-5141
Vision	EyeMed	www.evemedvisioncare.com www.enrollwiththeyemed.com	1-866-939-3633

PLAN COVERAGE	MERITAIN (North American) PPO	ADVANTAGE HEALTH (HMO)	MERITAIN (North American) HMO												
General Information	Under Meritain PPO, you must call Meritain at the toll-free number, 1-888-668-6855 (on the back of your ID card) before you or a covered family member is admitted to the hospital. Your admission and length of your hospital stay will be reviewed, and if approved, you'll receive benefits based on whether you receive care from a network provider or non-network provider. Lists of Network physicians and hospitals are available at www.selecthealthnetwork.com (Local Network) or www.beechstreet.com (National Network). In the case of a life-threatening emergency, notification to the toll-free number, 1-888-668-6855, must be initiated within 48 hours or the first business day following hospital admission. If a call is not made, a reduced benefit may be paid.	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(PCP) 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. A 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 <i>(full-time Faculty, Administrators and Staff)</i>	<table border="0"> <tr> <td>Individual coverage</td> <td>\$ 47.00</td> </tr> <tr> <td>Family coverage</td> <td>\$182.00</td> </tr> </table>	Individual coverage	\$ 47.00	Family coverage	\$182.00	<table border="0"> <tr> <td>Individual coverage</td> <td>\$ 29.00</td> </tr> <tr> <td>Family coverage</td> <td>\$ 117.00</td> </tr> </table>	Individual coverage	\$ 29.00	Family coverage	\$ 117.00	<table border="0"> <tr> <td>Individual coverage</td> <td>\$ 35.00</td> </tr> <tr> <td>Family coverage</td> <td>\$130.00</td> </tr> </table>	Individual coverage	\$ 35.00	Family coverage	\$130.00
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Individual coverage	\$ 35.00														
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Deductibles (Do not cross accumulate between in-network and out-of-network)	<table border="0"> <tr> <td></td> <td style="text-align: center;"><u>Individual</u></td> <td style="text-align: center;"><u>Family</u></td> </tr> <tr> <td><u>In-Network</u></td> <td style="text-align: center;">\$400</td> <td style="text-align: center;">\$800</td> </tr> <tr> <td><u>Out-of-Network</u></td> <td style="text-align: center;">\$800</td> <td style="text-align: center;">\$1600</td> </tr> </table>		<u>Individual</u>	<u>Family</u>	<u>In-Network</u>	\$400	\$800	<u>Out-of-Network</u>	\$800	\$1600	None	None			
	<u>Individual</u>	<u>Family</u>													
<u>In-Network</u>	\$400	\$800													
<u>Out-of-Network</u>	\$800	\$1600													
Co-insurance (Your share of eligible expenses)	<p><u>In-Network:</u> After you meet your annual deductible, the plan pays 85% of eligible charges and you pay the remaining 15%.</p> <p><u>Out-of-Network:</u> After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges and you pay the remaining 35% plus any amounts above reasonable & customary.</p>	None (Except applicable co-payments)	None (Except applicable co-payments)												

PLAN COVERAGE	MERITAIN (North American) PPO	ADVANTAGE HEALTH (HMO)	MERITAIN (North American) HMO									
<p>Out-of-pocket limits Includes the annual deductible. (Note: Once the out-of-pocket limit is met on an annual basis, the plan pays 100% of eligible charges. No one family member may meet this limit for the whole family.)</p>	<table> <thead> <tr> <th></th> <th><u>Individual</u></th> <th><u>Family</u></th> </tr> </thead> <tbody> <tr> <td>In-Network</td> <td>\$1,250</td> <td>\$3,000</td> </tr> <tr> <td>Out-of-Network</td> <td>\$2,500</td> <td>\$5,000</td> </tr> </tbody> </table>		<u>Individual</u>	<u>Family</u>	In-Network	\$1,250	\$3,000	Out-of-Network	\$2,500	\$5,000	Not Applicable	Not Applicable
	<u>Individual</u>	<u>Family</u>										
In-Network	\$1,250	\$3,000										
Out-of-Network	\$2,500	\$5,000										
<p>Physician Office Visits (Co-payments)</p>	<p><u>In-Network:</u> \$20 physician co-payment per office visit (after the co-payment is made, the plan pays 100%). This \$20.00 co-payment is still required even after deductible is met.</p> <p><u>Out-of-Network:</u> Subject to annual deductible. After you meet your annual deductible, the plan pays 65% of eligible, reasonable, and customary charges and you pay the remaining 35% plus any amounts above reasonable & customary.</p>	<p><u>Primary Care Physician</u> 100% after \$20 co-payment per primary care physician office visit.</p> <p><u>Specialist Physician</u> 100% after \$30 co-payment per specialist physician office visit (referral required).</p>	<p><u>Primary Care Physician</u> 100% after \$20 co-payment per primary care physician office visit. (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.)</p> <p><u>Specialist Physician</u> 100% after \$30 co-payment per specialist physician office visit.</p>									
<p>Physician Hospital Visits</p>	<table> <tbody> <tr> <td><u>In-Network:</u></td> <td>85%</td> </tr> <tr> <td><u>Out-of-Network:</u></td> <td>65%</td> </tr> </tbody> </table> <p>After annual deductible is met.</p>	<u>In-Network:</u>	85%	<u>Out-of-Network:</u>	65%	No Charge	No Charge					
<u>In-Network:</u>	85%											
<u>Out-of-Network:</u>	65%											
<p>Ambulance</p>	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.									
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Anesthesiology, Cardiac and Intensive Care	<u>Network:</u> 85% <u>Out-of-Network:</u> 65% After annual deductible is met.	No Charge	No Charge
Cardiac Rehabilitation	<u>Network:</u> 85% <u>Out-of-Network:</u> 65% After annual deductible is met.	\$30 specialist co-payment per office visit. 60 visits per each distinct condition or episode.	\$30 specialist co-payment per office visit. 36 visits per year.
Children Eligibility <i>(Due to age)</i>	Children are eligible until they reach age 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.)	Meritain is primary for you (the employee), and your spouse's employer's insurance plan is primary for him or her. The two plans "coordinate" benefits for your dependent children. The "birthday rule" determines which plan is primary (pays first) for your dependent children. For example, if the month and day your birthday falls during the year is <u>before</u> your spouse's birthday, Meritain 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.	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 dependents. Advantage will coordinate benefits with the primary Carrier. Applicable co-payments will still apply.	Meritain is primary for you (the employee), and your spouse's employer's insurance plan is primary for him or her. The two plans "coordinate" benefits for your dependent children. The "birthday rule" determines which plan is primary (pays first) for your dependent children. For example, if the month and day your birthday falls during the year is <u>before</u> your spouse's birthday, Meritain will be primary and pay benefits first for your dependents. If another plan is primary, Meritain HMO will consider the remaining eligible charges. Meritain HMO would coordinate for any service within their network.
PLAN COVERAGE	MERITAIN (North American) PPO	ADVANTAGE HEALTH (HMO)	MERITAIN (North American) HMO

Diabetic Supplies Part of the Pharmacy Benefit.	Not Applicable	Not Applicable	Not Applicable
Durable Medical Equipment	<p><u>In-Network</u> After deductible, plan pays 85% of eligible charges up to annual maximum.</p> <p><u>Out-of-Network</u> After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges up to the annual maximum.</p> <p>Annual maximum of \$15,000 per person / per year.</p>	Covered in full; \$2,500 maximum per calendar year.	Covered in full with prior approval from Meritain Health.
Emergency Services <i>(Out-of-Area/Out-of-State)</i>	You are not required to contact Meritain before seeking medical treatment. If a network provider is used, benefits are paid at 85% after deductible. If an out-of-network provider is used, benefits are paid at 65% of U&C (usual and customary) after deductible. If you are out of the area at the time emergency treatment is required, and it is not life threatening, you may call Beech Street at 1-800-432-1776 to locate the nearest national network provider. If the medical emergency turns into an inpatient hospital admission, the physician or the employee should contact Meritain within 48 hours to have the stay pre-certified.	<p>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.</p> <p>\$100 co-payment for Emergency Room</p> <p>Routine medical care and non-emergency care received out of town is not covered.</p>	<p>Out-of-Service Area, seek emergency services and notify Meritain Health Plan within 48 hours to assist with the processing of the claim. Should the employee have any questions, they can reach Meritain Health (HMO) at 1-888-668-6855.</p> <p>\$100 co-payment for Emergency Room</p> <p>Routine medical care and non-emergency care received out of town is not covered.</p>
Emergency Services <i>(In-Area)</i>	<p><u>Network:</u> 85%</p> <p><u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met.</p> <p><u>Urgent Care</u> \$50 co-payment for services provided at Urgent Care Center.</p>	<p>\$100 co-payment for Emergency Room (waived if patient is admitted).</p> <p><u>Urgent Care</u> \$40 co-payment for services provided at Urgent Care Center.</p>	<p>\$100 co-payment for Emergency Room (waived if patient is admitted).</p> <p><u>Urgent Care</u> \$40 co-payment for Urgent Care Facility at MedPoint and other CHA Urgent Care providers. \$25 co-pay for urgent care at Medpoint Express.</p>
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Fertility Testing and	<u>Network:</u> 85%	\$20 co-payment per primary care physician	\$20 co-payment per office visit for Out-

Counseling	<p>Out-of-Network: 65%</p> <p>After annual deductible is met.</p> <p>Provides coverage for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.</p>	<p>office visit for Out-Patient charges. \$30 co-pay per office visit for specialist \$350 hospital co-payment for In-Patient stays \$100 co-payment for out-patient surgery.</p> <p>Provides coverage for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.</p>	<p>Patient charges from a PCP. \$30 co-pay per office visit for specialist \$350 hospital co-payment for In-Patient stays. \$100 co-payment for out-patient surgery.</p> <p>Provides coverage for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.</p>
Home Health Care	<p>Network: 85%</p> <p>Out-of-Network: 65%</p> <p>After annual deductible is met and if determined to be medically necessary. Subject to \$25,000 annual maximum/\$50,000 lifetime maximum. There may be some limitations.</p>	<p>100% after \$20 co-payment per visit. There may be some limitations.</p>	<p>100% after \$20 co-payment per visit. Limit of 60 visits per Calendar Year.</p>
Hospital Room & Board	<p>Network: 85%</p> <p>Out-of-Network: 65%</p> <p>After annual deductible is met.</p>	<p>A \$350 hospital co-payment is required per person per hospital admission. Maximum of \$700 per person/\$1,400 per family for in-patient services per plan year (the \$700 per person charge is two hospital admissions; the \$1,400 is four hospital admissions).</p>	<p>A \$350 hospital co-payment is required per person per hospital admission. Maximum of \$700 per person/\$1,400 per family for in-patient services (the \$700 per person charge is two hospital admissions; the \$1,400 is four hospital admissions).</p>
Human Organ Transplants	<p>Meritain utilizes Life Trac as their program for transplants and other services. Life Trac program offers over 30 hospitals across the US including, Chicago Medical Center, University of Michigan Medical Center, Memorial Sloan-Kettering Cancer Center, and MD Anderson.</p>	<p>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.</p>	<p>Liver, heart, kidney, cornea, bone marrow--are treated the same as hospital inpatient expenses.</p> <p>Meritain utilizes Life Trac as their program for transplants and other services. Life Trac program offers over 30 hospitals across the US including, Chicago Medical Center, University of Michigan Medical Center, Memorial Sloan-Kettering Cancer Center, and MD Anderson.</p>
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Hospitals	<ul style="list-style-type: none"> St. Joseph Community Hospital, Mishawaka, IN; 	<ul style="list-style-type: none"> Community Hospital of Bremen, Bremen, IN 	<ul style="list-style-type: none"> Memorial Hospital, South Bend, IN; Adams County Memorial Hospital,

	<ul style="list-style-type: none"> • St. Joseph Regional Medical Center, Plymouth, IN; • St. Joseph's Regional Medical Center, South Bend, IN; • Memorial Hospital Mother and Child Care Center and neo-natal nursery are included as in-network services. • Community Hospital of Bremen, Bremen, IN • Goshen General Hospital, Goshen, IN • Indiana University Medical Center, Indianapolis, IN • Lakeland Regional Medical Center, Niles, MI • La Porte Hospital, La Porte, IN • Methodist Hospital, Indianapolis, IN • Riley Children's Hospital, Indianapolis, IN • Saint Anthony Hospital, Michigan City, IN • South Haven Community Hospital, South Haven, MI <p>(See directory or web page for a complete listing.)</p>	<ul style="list-style-type: none"> • 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. 	<p>Decatur, IN;</p> <ul style="list-style-type: none"> • Bloomington Hospital; Bloomington, IN; • Clarian/I.U. Medical Center, Indianapolis, IN; • Clarian/Riley Hospital for Children, Indianapolis, IN; • Community Hospital of Bremen, Bremen, IN; • Elkhart General Hospital, Elkhart, IN; • LaPorte Hospital, LaPorte, IN; • Madison Hospital, South Bend, IN 46617; • Lakeland Medical Center-Niles, Niles, MI; • Oaklawn Psychiatric Center, Inc., Goshen, IN; • St. Anthony Memorial Health Center, Michigan City, IN; • University of Chicago Hospitals, Chicago, IL; <p>(See directory or web page for a complete listing.)</p>
<p>Laboratory & X-Ray (Billed by a radiologist, pathologist or hospital)</p>	<p>Network: 85%</p> <p>Out-of-Network: 65%</p> <p>After annual deductible is met.</p>	<p>No Charge</p>	<p>No Charge</p>
<p>PLAN COVERAGE</p>	<p>MERITAIN (North American) PPO</p>	<p>ADVANTAGE HEALTH (HMO)</p>	<p>MERITAIN (North American) HMO</p>
<p>Maternity (No pre-existing conditions apply)</p>	<p>Network: Maternity benefits are administered under a</p>	<p>100% after \$20 PCP co-pay per office visit. 100% after \$30 co-pay per office visit.</p>	<p>100% after \$20 PCP co-pay per office visit. 100% after \$30 specialist co-pay per visit</p>

	<p>global fee charge at the time of delivery. Global fees include antepartum care (visits to doctor prior to delivery), delivery services (vaginal delivery --- with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visit following delivery). Because of the global fee, the \$20 co-payment may not be required at each office visit. Subject to annual deductible and 85% coinsurance.</p> <p>Memorial Hospital Mother and Child Care Center and neo-natal nursery are included as in-network services.</p> <p>Baby Steps is a program offered by Meritain that offer case management to High-risk pregnancies.</p> <p><u>Out-of-Network:</u> Pre-natal and post-natal office visits and delivery---subject to annual deductible and 65% coinsurance.</p> <p><i>Baby needs to be enrolled within 31 days of birth.</i></p>	<p>100% after \$30 co-pay for specialist Delivery fee is the same as regular hospitalization.</p> <p>Delivery Fee: \$350 hospital co-payment per person per admission.</p> <p>One hospitalization co-pay applies for mother and child providing mother and child are discharged at the same time.</p> <p><i>Baby needs to be enrolled within 31 days of birth.</i></p>	<p>Maternity benefits are administered under a global fee charge at the time of delivery. Global fees include antepartum care (visits to doctor prior to delivery), delivery services (vaginal delivery --- with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visit following delivery). Because of the global fee, the \$20 co-payment may not be required at each office</p> <p>Delivery fee: \$350 hospital co-payment per person per admission.</p> <p>One hospitalization co-pay applies for mother and child providing mother and child are discharged at the same time</p> <p>Baby Steps is a program offered by Meritain that offer case management to High-risk pregnancies.</p> <p><i>Baby needs to be enrolled within 31 days of birth.</i></p>
<p>Mental Health Services <i>(In-patient)</i></p>	<p><u>Network:</u> 85% <u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met for physician (M.D., Ph.D. and Licensed Clinical Social Worker) services. Limited to 60 days a year. (Less in-patient alcoholism/drug abuse days used).</p>	<p>100% after \$350 co-payment per admission.</p> <p>Pre-authorization by Midwest Behavioral Health Network Case Manager required to determine “medical necessity” and duration.</p>	<p>100% after \$350 co-payment per admission (M.D., Ph.D. and Licensed Clinical Social Worker). Limited to 60 days per member per year (less in-patient alcoholism/drug abuse days used).</p> <p>Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your therapist.</p>
<p>PLAN COVERAGE</p>	<p>MERITAIN (North American) PPO</p>	<p>ADVANTAGE HEALTH (HMO)</p>	<p>MERITAIN (North American) HMO</p>
<p>Mental Health Services <i>(Out-patient)</i></p>	<p><u>In-Network:</u> 85% <u>Out-of-Network:</u> 65%</p>	<p>Out-patient visits as determined medically appropriate by a Midwest Behavioral Health</p>	<p>Pre-authorization by a Clinical Case Manager will determine medical necessity and duration</p>

	After annual deductible is met for physician (M.D., Ph.D. and Licensed Clinical Social Worker) services. Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment. Limited to 50 visits per year. (Less out-patient alcoholism/drug abuse visits used).	Network Case Manager for detoxification, short term evaluation and/or crisis intervention. 100% after \$30 co-payment per office visit. Limited to 60 visits per distinct condition or episode.	in collaboration with your participating mental health professional. Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment for physician services (M.D., Ph.D. and Licensed Clinical Social Worker) per office visit. Limited to 20 visits per contract year per member when medically necessary (less out-patient alcoholism/drug abuse visits used.)
Occupational Therapy	<u>In-Network:</u> \$20 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 \$30 co-payment per office visit. Otherwise, not covered.	100% after \$30 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	<u>In-Network:</u> \$20 co-payment per visit. <u>Out-of-Network:</u> 65% After annual deductible is met.	100% after a \$30 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 \$30 co-payment per office visit for up to 20 outpatient visits. Long-term rehabilitation is not covered.
Orthotic Appliances <i>(such as braces or splints)</i>	<u>In-Network:</u> 85% After deductible, up to annual maximum. <u>Out-of-Network:</u> 65% after annual deductible up to the annual maximum. Annual maximum of \$10,000 per person / per year.	Covered in full; up to annual \$2,500 maximum per calendar year. (Some limitations and exclusions apply, such as foot Orthotics.)	Covered in full. (Some limitations and exclusions apply.)
PLAN COVERAGE	MERITAIN (North American) PPO	ADVANTAGE HEALTH (HMO)	MERITAIN (North American) HMO
Preventive Care – • Physical Exam • Well Woman Care (including	IN-NETWORK ONLY Participants age 7 and over • \$20 physician co-payment; 1 per year. • \$20 physician co-payment; 1 per year	No age limit All services are covered 100% after \$20 PCP co-payment per office visit. 100% after \$30 specialist co-pay per office visit	No age limit All services are covered 100% after \$20 PCP co-payment per office visit. 100% after \$30 specialist co-pay per office visit.

<p>Pap test)</p> <ul style="list-style-type: none"> Mammogram Blood Screening (plus blood pressure/height and weight) Sigmoidoscopy Occult blood Prostate-Specific Antigen (PSA) Eligible immunizations: DPT, MM, Tuberculin skin test and annual flu shot. 	<ul style="list-style-type: none"> Baseline at age 35; 1 per year after age 40. 1 per year 1 per year after age 50. 1 per year after age 40. 1 per year after age 50. 18 years of age and older - only applicable to eligible immunizations. <p>(State mandated immunizations are covered at any age.)</p>	<p>Services must be provided by a primary care physician.</p>	<ul style="list-style-type: none"> Baseline at age 35; 1 per year after age 40. 1 per year after age 50. <p>Services must be provided by a primary care physician (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.)</p>
<p>Preventive Care - Children</p> <ul style="list-style-type: none"> Periodic well care checkups Well-baby care Immunizations/inoculations 	<p>Under age 7</p> <p><u>In-Network:</u> \$20 physician co-payment per office visit</p> <p><u>Out-of-Network:</u> Subject to annual deductible and 65% coinsurance.</p> <p>(State mandated immunizations are covered at any age.)</p>	<p>No age limit</p> <p>All services are covered 100% after \$20 co-payment per office visit.</p>	<p>No age limit</p> <p>All services are covered 100% after \$20 co-payment per office visit.</p> <p>Services must be provided by a PCP (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.)</p>
<p>PLAN COVERAGE</p>	<p>MERITAIN (North American) PPO</p>	<p>ADVANTAGE HEALTH (HMO)</p>	<p>MERITAIN (North American) HMO</p>
<p>Prosthesis</p>	<p><u>In-Network:</u> After deductible, plan pays 85% of eligible charges up to annual maximum.</p> <p><u>Out-of-Network:</u></p>	<p>Covered in full (excluding artificial limbs). Limit up to annual maximum of \$2,500.</p>	<p>Covered in full.</p>

	<p>After you meet your annual deductible, the plan pays 65% of eligible, reasonable and customary charges.</p> <p>Annual maximum of \$20,000 per person / per year.</p>		
Skilled Nursing Facility	<p><u>In-Network:</u> 85% <u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met if medically necessary. No custodial care.</p>	<p>No charge for up to 100 days per Medicare guidelines and following a hospital stay. Custodial care is not covered.</p>	<p>No charge for up to 60 days per calendar year, if medically necessary. No custodial care.</p>
<p>Substance Abuse Services <i>(In-patient)</i> <i>Cross-accumulation with mental health.</i></p>	<p><u>In-Network:</u> 85% <u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met and if confined in an approved facility. Limit of 60 days per year. Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional (M.D., Ph.D. and Licensed Clinical Social Worker) (Less inpatient mental health services).</p>	<p>Pre-authorization by 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 \$350 co-payment per admission. Limited to a maximum of 14 days per calendar year.</p>	<p>Pre-authorization by a Clinical Case Manager will determine medical necessity and duration in collaboration with your participating mental health professional (M.D., Ph.D. and Licensed Clinical Social Worker); covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$350 co-payment per admission; limited to 60 days per member per calendar year. (Less Inpatient mental health services).</p>
PLAN COVERAGE	MERITAIN (North American) PPO	ADVANTAGE HEALTH (HMO)	MERITAIN (North American) HMO

<p>Substance Abuse Services (Out-patient) Cross-accumulation with mental health.</p>	<p><u>In-Network:</u> 85% <u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met for physician (M.D., Ph.D. and Licensed Clinical Social Worker) services. Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment. Limited to 50 visits per year. (Less out-patient mental nervous visits used).</p>	<p>Out-Patient visits as determined medically appropriate by a Midwest Behavioral Health Network Case Manager for detoxification, short-term evaluation, and/or crisis intervention. \$30 co-payment per visit. Limited to 20 visits per member per year. (\$30 co-payment waived for group therapy.)</p>	<p>Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment per office visit (M.D., Ph.D. and Licensed Clinical Social Worker.) Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment.</p> <p>Limited to 20 visits per contract year per member when medically necessary (Less out-patient mental nervous visits used).</p>
<p>Surgery / In-patient</p>	<p><u>Network:</u> 85% <u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met.</p>	<p>No charge (\$350 hospital co-payment applies).</p>	<p>No charge (\$350 hospital co-payment applies).</p>
<p>Surgery / Out-patient (office)</p>	<p><u>In-Network:</u> 85% <u>Out-of-Network:</u> 65%</p> <p>After annual deductible is met. Services are not considered the same as a routine office visit and do not qualify for payment at 100% after a \$20 co-payment.</p>	<p>100% after \$100 co-payment per procedure.</p> <p>Services are not considered the same as a routine office visit and do not qualify for payment at 100% after a \$20 PCP co-payment and \$30 co-pay per specialist visit.</p>	<p>100% after \$100 co-payment per procedure.</p> <p>Services are not considered the same as a routine office visit and do not qualify for payment at 100% after a \$20 PCP co-payment and \$30 co-pay per specialist visit.</p>
<p>TMJ (Temporomandibular Joint Syndrome)</p>	<p>Non-Surgical treatment covered at 85% in-network and 65% UCR out of network, subject to deductible up to \$1000 yearly maximum and \$3000 lifetime maximum.</p> <p>Inpatient and Outpatient Hospitalization (Surgical Benefit) is covered at 85% in network and 65% UCR out of network, subject to deductible.</p>	<p>Not Covered</p>	<p>Not Covered</p>
<p>Voluntary Abortion and/or Sterilization</p>	<p>Not Covered</p>	<p>Not Covered</p>	<p>Not Covered</p>

PRESCRIPTION BENEFIT- WITH ALL MEDICAL PLANS

Program Administrated by Medco www.medco.com

1-800-771-0917

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

	Participating Retail Pharmacy Up to a 30-day supply	Mail Service Up to a 90-day supply
Generic	\$8	\$20
Brand formulary	\$20	\$45
Brand non-formulary	\$35	\$75

What is a formulary?

A formulary is a cost-effective solution to help you with select prescription drugs for your 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

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.

Mail Service Requirement:

You may receive your first three refills for long-term or maintenance medications under the retail network service. Your fourth and future refills must be obtained through the mail service to avoid higher co-payments. Long-term or maintenance medications filled at retail after the **first three refills** will be subject to **double** the retail co-payments for up to a 30-day supply (\$20 for generic, \$45 for brand, or \$75 for brand non-formulary)

By using the mail service program you can receive up to a 90 day supply of long-term or maintenance medication for two months worth of retail co-payments. Mail service co-payments are as follows: \$20 generic, \$45 brand, or \$75 brand non-formulary.

Oral Contraceptives:

Drug treatment for correction of existing pathologies of the reproductive system only.

No payment will made for expenses incurred:

- For oral contraceptive or contraceptive devices, except when specifically requested by a physician based on medical necessity and for purposes other than contraception. Contraceptive implants, such as Norplant, are not considered Covered Prescription Drugs.
- For oral and injectable fertility drugs administered in conjunction with artificial insemination, in-vitro fertilization (IVF), GIFT, ZIFT or any other treatment designed

VISION PLAN

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

Vision Care	Member Cost	Out-of-Network Allowance
Exam with dilation as Necessary (Glasses):	\$10 co-payment	Up to \$35
Standard Plastic Lenses:		
Single Vision	\$10 co-payment	Up to \$25
Bifocal	\$10 co-payment	Up to \$40
Trifocal	\$10 co-payment	Up to \$55
Lenticular	\$10 co-payment	Up to \$55
Frames:		
Any frame available at provider location	\$0 co-payment, \$100 allowance for any frame plus 20% off balance over \$100	Up to \$45
Lens Options:		
UV Coating	\$12	N/A
Tint (Solid and Gradient)	\$12	N/A
Standard Scratch-Resistance	\$15	N/A
Standard Polycarbonate	\$35	N/A
Standard Progressive-(add-on to Bifocal)	\$45	N/A
Standard Anti-Reflective	\$45	N/A
Other Add-Ons and Services	20% discount	N/A
Contact Lenses:		
(Includes exam, fit, follow-up, and materials)		
Conventional	\$0 co-payment, plus 15% discount off balance over \$115	Up to \$100
Disposables	\$0 co-payment, plus balance over \$115	Up to \$100
Medically Necessary	\$0 co-payment, plus balance over \$250	Up to \$200
Laser Vision Correction:		
Lasik or PRK From US Laser Network	15% of retail price or 5% off promotional price	N/A
Frequency:		
Examination	Once every 12 months	
Frame	Once every 24 months	
Lenses or Contact Lenses	Once every 12 months	
Vision Premiums per month		
	Individual \$6.68	
	Family \$15.88	

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

Premier-Plus Secondary Purchase Discount

Vision Care Services	Member Cost
Exam with dilation as Necessary (glasses):	\$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 Standard 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 and/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 (PPO)	Health Resources, Inc. (HMO)
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 child loses eligibility their coverage will terminate the end of the calendar month in which they lose eligibility.	Children are eligible up to the age of 19. If they are a full-time student they may be covered up to the age of 25. If a child loses eligibility their coverage will terminate the end of the calendar month in which they lose eligibility.
Dental Premiums per month	2006 Individual \$15.44 2007 Individual \$17.68 Family \$59.44 Family \$65.20	Individual \$27.92 Out of area: Individual \$36.68 Family \$86.72 Family \$110.08

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