ASR health benefits

Berrien RESA, G-731
Paraprofessional Employees

Benefit Description	POS Plan B		POS Plan C	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Benefit Year	July 1 through June 30		July 1 through June 30	
Deductible per Benefit Year	$500/person $1,000/family	$1,000/person $2,000/family	$2,500/person $5,000/family	$5,000/person $10,000/family
General Benefit Percentage	100% after deductible (0% coinsurance)	80% after deductible (20% coinsurance)	70% after deductible (30% coinsurance)	50% after deductible (50% coinsurance)
Coinsurance Maximum Out-of-Pocket per Benefit Year	$0/person $0/family	$3,000/person $6,000/family	$3,000/person $6,000/family	$15,000/person $30,000/family
Total Maximum Out-of-Pocket per Benefit Year	$3,000/person* $6,000/family*	Not applicable	$6,600/person* $13,200/family*	Not applicable
	*Includes deductible, Coinsurance Maximum Out-of-Pocket, and medical co-payments. Does not include prescription drug co-payments or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. Prescription drug co-payments track toward a separate Prescription Drug Maximum Out-of-Pocket to the extent required by Health Care Reform (see the Prescription Drugs benefit in this summary for more information).		*Includes deductible, coinsurance, medical co-payments, and prescription drug co-payments. Does not include expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded.	
Annual Maximum Paid per Covered Person per Benefit Year for All Covered Expenses	Unlimited		Unlimited	
Outpatient Physician Services (Includes Office Visits, Immediate Care Center Visits, and Second Surgical Opinions) Physician's Fee for an Examination	$35 co-payment per visit, then 100% (deductible waived)	80% after deductible	$30 co-payment per visit, then 100% (deductible waived)	50% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered
Routine Preventive Care Physician's Fee for an Examination Routine X-Rays and Lab Tests Flu Shots and Other Routine Immunizations FDA-Approved Contraceptive Methods and Sterilization Procedures for Women with Reproductive Capacity Mammograms, Colonoscopies, and Other Routine Services	100%; deductible waived	80% after deductible	100%; deductible waived	50% after deductible

Benefit Description	POS Plan B		POS Plan C	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine Preventive Care, cont. **Special Notes About Routine Preventive Care:** 1. Coinsurance or an office visit co-payment may be imposed on preventive care services if either the visit is billed separately from the preventive care service or the services are provided during an office visit whose primary purpose is not preventive care (and the services are not billed separately). 2. The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.				
Emergency Room Treatment				
Physician's Fee for an Examination in the Emergency Room	$150 co-payment* per visit, then 100% (deductible waived) *may waive if admitted	Paid as in-network	$150 co-payment* per visit, then 100% (deductible waived) *may waive if admitted	Paid as in-network
All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment	100% after deductible	Paid as in-network if treated at an in-network facility, or at 80% after deductible if treated at an out-of-network facility	70% after deductible	Paid as in-network if treated at an in-network facility, or at 50% after deductible if treated at an out-of-network facility
Hospital's Fee for the Use of the Emergency Room	100% after deductible	Paid as in-network	70% after deductible	Paid as in-network
All Other Services Billed by the Hospital or Any Other Provider in Connection with the Emergency Room Visit	100% after deductible	80% after deductible	70% after deductible	50% after deductible
Ambulance Transportation	100% after deductible	Paid as in-network if delivered to an in-network facility, or at 80% after deductible if delivered to an out-of-network facility	70% after deductible	Paid as in-network if delivered to an in-network facility, or at 50% after deductible if delivered to an out-of-network facility
Prescription Drugs Fill Limits -Retail Pharmacy Allows a 34-Day Supply -Mail-Order Program Allows a 90-Day Supply -Specialty Pharmacy Program (Dispenses Specialty Prescription Drugs Only) Allows a 30-Day Supply	$20/generic drug, $50/brand-name formulary drug, $100/brand-name non-formulary drug		$20/generic drug, $50/brand-name formulary drug, $100/brand-name non-formulary drug	
Prescription Drug Maximum Out-of-Pocket per Benefit Year	$3,600/person* $7,200/family* *Includes prescription drug co-payments only. Does not include amounts attributed to the Total Maximum Out-of-Pocket for medical services, any optional additional amount that the covered person must pay over and above the co-payment, or the cost of any drug or service that is not covered under the Plan.		Not applicable; co-payments track toward the medical Total Maximum Out-of-Pocket	

Special Notes About Prescription Drug Coverage:

1. The pharmacy will dispense generic drugs unless the prescribing physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the covered person refuses an available generic equivalent and the prescribing physician has not requested DAW, the covered person must pay the applicable co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.

2. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications, including, but not limited to, certain FDA-approved contraceptive agents and smoking cessation products with a prescription, as well as breast cancer medications that lower the risk of cancer or slow its development, without any cost-sharing provisions such as deductibles or co-payments. For more information about eligible preventive care medications, the covered person can contact the Pharmacy Benefits Manager (PBM) using the information listed on the front of his/her identification card.

3. The term "specialty prescription drug" means a drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty prescription drugs may be injectable medications, high-cost medications, or have special delivery and storage requirements (e.g., they may require refrigeration). **Specialty prescription drug purchases will be limited to a 30-day supply, and prescriptions for such drugs must generally be filled through Lumicera Health Services specialty pharmacy or the drug will not be eligible for coverage under the Plan.** For additional information about specialty prescription drugs, including information about which drugs are currently on the PBM's specialty prescription drug list, the Covered Person can contact the PBM using the information listed on the front of his/her identification card.

4. The Plan requires that a covered person purchase self-injectable medications through the Prescription Drugs benefit. For more information about self-injectable medications, the covered person can contact the PBM using the information listed on the front of his/her identification card.

Benefit Description	POS Plan B		POS Plan C	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Authorization Requirement Penalty for Non-Compliance: $100 if an Outpatient Service, $250 if an Inpatient Service	Suggested for all inpatient hospital admissions and observational stays at the hospital (no penalties apply); Required for inpatient hospice care and inpatient convalescent care. Also required for other outpatient services listed at the end of this summary.			
Inpatient Hospital Services Room and Board, Surgical Services, and Ancillary Services	100% after deductible	80% after deductible	70% after deductible	50% after deductible
Inpatient Physician Services Hospital Visits, Surgical Procedures, and Anesthesiology	100% after deductible	80% after deductible	70% after deductible	50% after deductible
Transplant-Related Services	Services not covered by the Organ and Tissue Transplant Policy are typically paid the same as for any other surgery, contingent upon prior approval of health plan. However, if services are performed at a Nonparticipating Transplant Facility (as defined in the Transplant Policy), no benefits are payable in excess of what is paid by the Transplant Policy.		Services not covered by the Organ and Tissue Transplant Policy are typically paid the same as for any other surgery, contingent upon prior approval of health plan. However, if services are performed at a Nonparticipating Transplant Facility (as defined in the Transplant Policy), no benefits are payable in excess of what is paid by the Transplant Policy.	
Outpatient Services Surgery and Surgery-Related Services Chemotherapy and Radiation Therapy Hemodialysis Diagnostic X-Rays and Lab Test Services	100% after deductible	80% after deductible	70% after deductible	50% after deductible
Allergy Services Injections, Serum, and Testing	100% after deductible	80% after deductible	70% after deductible	50% after deductible
Chiropractic Care Spinal Manipulations and Therapy Treatments Diagnostic Spinal X-Rays Physician's Fee for an Initial or Periodic Evaluation $200 Maximum Paid per Covered Person per Benefit Year for X-Rays (In-Network and Out-of-Network Services Combined) $1,000 Maximum Paid per Covered Person per Benefit Year for All Chiropractic Care (In-Network and Out-of-Network Services Combined)	 100% after deductible 100% after deductible $35 co-payment per visit, then 100% (deductible waived)	 80%; deductible waived 80%; deductible waived $35 co-payment per visit, then 100% (deductible waived)	 70% after deductible 70% after deductible $30 co-payment per visit, then 100% (deductible waived)	 50%; deductible waived 50%; deductible waived $30 co-payment per visit, then 100% (deductible waived)
Rehabilitative Therapy Physical Therapy, Speech Therapy, and Occupational Therapy	100% after deductible	80% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Prosthetics, and Orthotics	100% after deductible	80% after deductible	70% after deductible	50% after deductible

Benefit Description	POS Plan B		POS Plan C	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hearing Care Exams, Evaluations, Conformity Tests, and Hearing Aids $300 Maximum Benefit Paid for Audiometric Examinations, Hearing Aid Evaluations, and Conformity Tests per Covered Person in Any 36-Consecutive-Month Period $500 Maximum Benefit Paid for a Hearing Aid per Covered Person per Ear in Any 36-Consecutive-Month Period	100% after deductible	80% after deductible	70% after deductible	50% after deductible
Behavioral Care (Includes Mental Health Care and Addictions Treatment) Inpatient/Partial Hospitalization Services Outpatient/Intensive Outpatient Services	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Infertility Treatment $500 Lifetime Maximum Paid per Covered Person for All Eligible Infertility Treatment (In-Network and Out-of-Network Services Combined)	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Special Note About Infertility Treatment: Prescription drugs prescribed for the treatment of infertility will be covered under the Infertility Treatment benefit, but are not subject to the $500 lifetime maximum stated above.				
Temporomandibular Joint Dysfunction (TMJ) Treatment $1,000 Lifetime Maximum Paid per Covered Person for All Non-Surgical TMJ Treatment (In-Network and Out-of-Network Services Combined); The Plan Will Also Allow Charges for Surgery if All Other Means of Generally Accepted Treatment Have Been Exhausted.	Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Convalescent Care	100% after deductible	80% after deductible	70% after deductible	50% after deductible
Home Health Care 40 Visits per Covered Person per Benefit Year (In-Network and Out-of-Network Services Combined)	100% after deductible	80% after deductible	70% after deductible	50% after deductible
Hospice	100% after deductible	80% after deductible	70% after deductible	50% after deductible

Miscellaneous Plan Provisions for Plan B and Plan C

Service Suggested for Authorization:
Inpatient hospital admissions and observational stays at the hospital

Mandatory Services Requiring an Authorization:
1. **Home and outpatient rehabilitative therapy**
2. **Rental and purchase of durable medical equipment**
3. **Home health care**
4. **Purchase of custom-made orthotic or prosthetic appliances**
5. **Oncology treatment**
6. **Inpatient hospice care and inpatient convalescent care**

Penalty for noncompliance: $100 if an outpatient service, $250 if an inpatient hospice or convalescent care service

Personal Care Physician (PCP). A PCP must be selected when enrolling in the above Plan. PCPs are highlighted in the Physicians Care directory. When you seek medical services, contact your PCP, who will treat you or refer you to a specialist.

If a covered person's PCP refers the covered person to an out-of-network provider and that care is authorized through the Physicians Care referral process, eligible services will be paid at the in-network benefit level. If such care cannot be authorized through the Physicians Care referral process, services will be paid at the out-of-network benefit level.

If a covered person receives eligible treatment at an in-network facility, any anesthesiology, pathology, or radiology charges will be paid at the in-network benefit level, even if out-of-network providers performed those services.

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents
In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Coordination with Other Coverage for Injuries Arising out of Motorcycle Accidents
The following special coordination rule applies regarding motorcycle accidents. If a covered person is injured in an accident that involves a motor vehicle, claims will be processed in accordance with the Plan's position on motor vehicle accidents.

IF A COVERED PERSON IS OPERATING A MOTORCYCLE AND IS INJURED IN AN ACCIDENT THAT DOES NOT INVOLVE A MOTOR VEHICLE, THIS PLAN WILL EXCLUDE COVERAGE FOR THE FIRST $20,000 IN ELIGIBLE CHARGES OR, IF GREATER, THE AMOUNT OF HEALTH BENEFITS PAYABLE BY THE MOTORCYCLE INSURANCE POLICY. It is the responsibility of any covered person who operates a motorcycle to ensure that he or she is covered under a motorcycle insurance policy that will pay at least $20,000 in health benefits for him or her per accident. This requirement applies even if the covered person is not legally required to have such health benefit coverage. If the covered person fails to maintain $20,000 of coverage through a motorcycle insurance policy, the difference between the policy's maximum payout per accident (if any) and $20,000 will be the covered person's responsibility.
A covered person who is riding a motorcycle as a passenger and is injured in an accident that does not involve a motor vehicle will not be subject to this provision and will not have his or her otherwise eligible claims excluded from Plan coverage as described above.

Benefit Description	Vision Plan
	Limits
Benefit Year	July 1 through June 30
Benefit Percentage	
Vision Examinations	100% (0% coinsurance)
Eyeglass Frames	100% (0% coinsurance)
Eyeglass Lenses, Including Eyeglass Lens Add-Ons Such As Tinting, Ultraviolet Coatings, Scratch-Resistant Coatings, and Anti-Reflective Coatings	100% (0% coinsurance)
Contact Lenses	100% (0% coinsurance)
Maximum Benefit Paid per Covered Person in Any Two Benefit Years for All Eligible Vision Expenses	$500
NOTE: If disposable contact lenses are selected, the plan will cover all contact lenses purchased until the maximum benefit amount stated above is exhausted.	

Benefit Description	Dental Plan
	Limits
Benefit Year	July 1 through June 30
Benefit Percentage	
Type I - Preventive Dental Services	100% (0% coinsurance)
Type II - Minor Restorative Dental Services	100% (0% coinsurance)

Benefit Description	Dental Plan
	Limits
Benefit Percentage, cont. Type III - Major Restorative Dental Services Type IV - Orthodontic Services (for dependent children under age 19 only)	75% (25% coinsurance) 60% (40% coinsurance)
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II, and III Dental Services	$2,000
Lifetime Maximum Benefit Paid per Dependent Child for Type IV Orthodontic Services	$2,000

Summary of Dental Procedures

NOTE: Additional limitations may apply to the replacement of some items addressed below. See the subsection entitled "EXCLUSIONS AND LIMITATIONS FOR DENTAL BENEFITS" in the Plan document for more details.

Services:	***Special Limitations:***
Type I: Preventive Dental Services	
A. Oral Examination	Limited to two times in a Benefit Year.
B. Dental Prophylaxis (cleaning teeth)	Limited to two times in a Benefit Year.
C. Complete Series or Panorex X-Rays	Limited to one time in any 36-consecutive-month period.
D. Occlusal, Extraoral, and Individual Periapical X-Rays	None.
E. Bite-Wing X-Rays	Limited to two times in a Benefit Year.
F. Bacteriologic Cultures	None.
G. Fluoride Treatment	Dependent children under age 18 only. Limited to one in any Benefit Year.
H. Palliative Treatment	Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit.
I. Sedative Fillings	Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit.
J. Sealants	Dependent children under age 16 only.
K. Space Maintainers	None.
L. Emergency Treatment	Exams only.
Type II: Minor Restorative Dental Services	
A. Periodontal Exams	Limited to one time in any three-consecutive-month period.
B. Periodontal Prophylaxis	Limited to one time in any three-consecutive-month period.
C. Diagnostic Casts	Limited to one time in any 24-consecutive-month period.
D. Stainless Steel Crowns	None.
E. Re-cement Inlays, Onlays, Crowns, and Bridges	None.
F. Pulpotomy and Osseous Surgery	None.
G. Root Canal Therapy	None.
H. Apicoectomy and Retrograde Filling	None.
I. Scaling and Root Planing	Limited to two times per quadrant of the mouth in any 12-consecutive-month period.
J. Temporary Splinting	None.
K. Periodontal Appliance	Limited to one appliance in any 36-consecutive-month period.
L. Repairs to Full Dentures, Partial Dentures, and Bridges	Limited to repairs or adjustments done more than 12 months after the initial insertion.
M. Relining Dentures	Limited to relining done more than 12 months after the initial insertion and then not more than one time in any 24-consecutive-month period.

Summary of Dental Procedures NOTE: Additional limitations may apply to the replacement of some items addressed below. See the subsection entitled "EXCLUSIONS AND LIMITATIONS FOR DENTAL BENEFITS" in the Plan document for more details.	
Services:	***Special Limitations:***
Type II: Minor Restorative Dental Services, cont.	
N. Simple Extraction	None.
O. Surgical Extraction of Impacted Teeth	No special limitations. The employer's medical plan will provide primary coverage, and the employer's dental plan will coordinate as the secondary coverage on any unpaid balance.
P. Alveoplasty	No special limitations. The employer's medical plan will provide primary coverage, and the employer's dental plan will coordinate as the secondary coverage on any unpaid balance.
Q. Gingivectomy	No special limitations. The employer's medical plan will provide primary coverage, and the employer's dental plan will coordinate as the secondary coverage on any unpaid balance.
R. Vestibuloplasty	No special limitations. The employer's medical plan will provide primary coverage, and the employer's dental plan will coordinate as the secondary coverage on any unpaid balance.
S. Root Recovery	None.
T. Incision and Drainage	None.
U. Local and General Anesthesia	None.
V. Amalgam Restorations (fillings)	Multiple restorations on one surface will be treated as a single filling.
W. Silicate, Plastic, and Composite Restorations (fillings)	None.
X. Pin Retention	Limited to two pins per tooth.
Y. Gingival Curettage	None.
Z. Osseous Graft	None.
AA. Frenectomy	None.
BB. Occlusal Adjustment	None.
CC. Bite Splint Appliances	Limited to one appliance in any five-consecutive-year period.
Type III: Major Restorative Dental Services	
A. Gold Inlays and Onlays	Covered only when the tooth cannot be restored by silver fillings. An expense is considered incurred at the time the tooth or teeth are initially prepared.
B. Porcelain Restorations	None.
C. Crowns	Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.
D. Post and Core	None.
E. Replacement of Teeth to Bridges and Dentures	None.
F. Full or Partial Dentures	None.
G. Fixed Bridges	An expense is considered incurred at the time the tooth or teeth are initially prepared.
H. Dental Implants	None.
Type IV: Orthodontic Services (Dependent Children Under Age 19 Only)	
Orthodontic Diagnostic Procedures, Surgical Therapy, and Appliance Therapy	None.