UNIVERSITY OF NOTRE DAME

MEDICAL/DENTAL/VISION

PLAN SUMMARY 2024

MEDICAL/DENTAL/VISION PLAN SUMMARY - 2024

To help you make informed decisions about your insurance election, the University has prepared this 2024 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 30 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 30 days of the event, you may not make the change until the next Open Enrollment Period.)**

IMPORTANT CONTACT INFORMATION

Medical, Prescription, Dental, and Vision

Medical	**Anthem**	**anthem.com**	**1-833-835-2717**
Health Savings Account	**Fidelity**	**netbenefits.com/nd**	**1-800-544-3716**
Prescription	**OptumRx**	**optumrx.com**	**1-866-270-0234**
Dental	**Delta Premier** **Delta PPO, POS/Preferred**	**deltadentalin.com** **consumertoolkit.com**	**1-800-524-0149**
Vision	**EyeMed**	**eyemedvisioncare.com** **enrollwitheyemed.com**	**1-866-939-3633**
Notre Dame Wellness Center	**Premise Health**	**notredamewellnesscenter.com**	**(574) 634-WELL (9355)**
Notre Dame Wellness Center Pharmacy	**Walgreens**	**notredamewellnesscenter.com**	**(574) 271-5622**
Telemedicine	**LifeHealth Online**	**Livehealthonline.com**	**1-888-548-3432**

In-Network Hospital Information

(See anthem.com for a complete and up-to-date listing)

Dependent Verification for Health Plans

The University of Notre Dame requires faculty and staff who are eligible for the health plan to provide documentation that supports current spousal or child relationship when enrolling a dependent in the plan.

Copies of your documents should be submitted with your Benefits Enrollment.

Who is an eligible dependent?

- Your legal spouse as defined by the state of Indiana
- Your children up to age 26 who are your biological children, stepchildren, adopted children, disabled children who are unmarried and became disabled prior to age 26, and children for whom you are a court appointed guardian
- Any child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO)

Who is not eligible?

- Your common law spouse
- Your parents
- Your ex-spouse (even if you are legally responsible for providing coverage)
- Your grandchildren, nieces and nephews for whom you are not a court appointed guardian

The table below lists the documents that will be accepted for each type of dependent. Please note in certain situations, two types of documentation may be required.

Please submit copies of the original documents through MyBenefits.nd.edu or to the Office of Human Resources located in 200 Grace Hall.

IMPORTANT: Please include your NDID number on all copies of documentation submitted.

Acceptable Dependent Eligibility Documents	
Dependent	**Documentation Required**
Legal Spouse (The covered employee's spouse under Indiana Law)	Documentation must support the current spousal relationship. - Government issued marriage certificate and Federal Tax Return within the last 2 years* **OR** - Government issued marriage certificate and proof of joint ownership issued within the last 6 months **OR** - Government issued marriage certificate only (if married in the last 12 months)
Biological Child (Under age 26)	Government issued birth certificate or birth confirmation letter from hospital
Disabled Biological Child (Over age 26;	Government issued birth certificate and Federal Tax Return within last two years claiming child*

unmarried; medically certified as disabled; financially supported by employee and spouse)	
Adopted Child (Under age 26)	Adoption placement and petition for adoption **OR** adoption certificate
Disabled Adopted Child (Over age 26; unmarried; medically certified as disabled; financially supported by employee and spouse)	Adoption certificate and Federal Tax Return within last 2 years claiming child*
Stepchild (Under age 26)	- Government issued birth certificate, government issued marriage certificate and Federal Tax Return within last 2 years * **OR** - Government issued birth certificate and government issued marriage certificate (if married within the last 12 months) **OR** - Government issued birth certificate, government issued marriage certificate and a proof of joint ownership issued within last 6 months
Disabled Stepchild (Over age 26; unmarried; medically certified as disabled; financially supported by employee and spouse)	- Government issued birth certificate, government issued marriage certificate and Federal Tax Return within last 2 years listing spouse and claiming child * **OR** - Government issued birth certificate and government issued marriage certificate (if married within the last 12 months) **OR** - Government issued birth certificate, government issued marriage certificate and a proof of joint ownership issued within last 6 months
Legal Guardian	Government issued birth certificate and court ordered document of legal custody
Disabled Legal Guardian (Over age 26; unmarried; must be medically certified as disabled; financially supported by employee and spouse)	Government issued birth certificate, court ordered document of legal custody and Federal Tax Return within last 2 years claiming child
Qualified Medical Support Order (Age 18 and under; QMSO must be ordered for the employee)	Qualified Medical Child Support Order

*Please submit page 1 only of the Federal Tax Return. Black out all monetary amounts and Social Security Numbers.

You will have 30 days from your benefit effective date or qualifying event date to provide this documentation. If documentation is not received within this timeframe, applicable dependents will not be enrolled. The next opportunity to enroll will then be during open enrollment or if you experience a qualifying event.

<table>
<tr><th>PLAN COVERAGE</th><th colspan="2">ANTHEM - PPO</th><th colspan="2">ANTHEM – HSA 1</th><th colspan="2">ANTHEM – HSA 2</th></tr>
<tr><td>Precertification Requirements</td><td colspan="6">You, your eligible Dependents or a representative acting on your behalf, must call Anthem at 1-833-835-2717 to receive precertification of Inpatient admissions (other than admissions for an Emergency Medical Condition), as well as other non-Emergency Services listed below. This call must be made at least 24 hours in advance of Inpatient admissions or receipt of the non-Emergency Services listed below.
o Developmental delays
o Inpatient admissions, including inpatient admissions to a Skilled Nursing Facility, Extended Care Facility, Rehabilitation Facility, and inpatient admissions due to a Mental Disorder or Substance Use Disorder
o Orthopedic surgeries for spine and hip procedures
If the Inpatient admission is with respect to an Emergency Medical Condition, you must notify Anthem within 48 hours or if later, by the next business day after the Emergency Medical Condition admission. Failure to obtain precertification or notify Anthem within the time frame indicated above will result in eligible expenses being reduced or denied.</td></tr>
<tr><td>Monthly Premiums
(full-time Faculty and Staff)</td><td>Individual
Individual + 1
Family</td><td>$124.00
$289.00
$394.00</td><td>Individual
Individual + 1
Family</td><td>$81.00
$201.00
$262.00</td><td>Individual
Individual + 1
Family</td><td>$33.00
$105.00
$117.00</td></tr>
<tr><td>Employer Contribution to Funding Account</td><td colspan="2">N/A</td><td></td><td>HSA
Individual
Individual + 1
Family</td><td></td><td>HSA
Individual
Individual + 1
Family</td></tr>
<tr><td>Calendar Year Deductibles</td><td colspan="2"><u>Individual</u> <u>Family</u>
<u>In-Network</u> $500 $1,000
<u>Out-of-Network</u> $1,000 $2,000

(Does not cross accumulate between in-network and out-of-network.)</td><td colspan="2"><u>Individual</u> <u>Family</u>
<u>In-Network</u> $2,000 $3,750
<u>Out-of-Network</u> $4,000 $7,500

(Does not cross accumulate between in-network and out-of-network. First dollar applies while still in deductible. True Family Deductible applies)</td><td colspan="2"><u>Individual</u> <u>Family</u>
<u>In-Network</u> $3,000 $6,000
<u>Out-of-Network</u> $6,000 $12,000</td></tr>
<tr><td>Co-Insurance</td><td colspan="2"><u>In-Network</u>
85% of eligible charges after deductible (Employee pays remaining 15%)

<u>Out-of-Network</u>
65% of eligible, reasonable, and customary charges after deductible (Employee pays remaining 35% plus any amounts above reasonable & customary.)</td><td colspan="4"><u>In-Network</u>
85% of eligible charges after deductible (Employee pays remaining 15%)

<u>Out-of-Network</u>
65% of eligible, reasonable, and customary charges after deductible
(Employee pays remaining 35% plus any amounts above reasonable & customary.)</td></tr>
<tr><td>Calendar Year 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.)</td><td colspan="2"><u>Individual</u> <u>Family</u>
<u>In-Network</u> $3,000 $6,000
<u>Out-of-Network</u> $6,000 $12,000

Medical and prescription drug copays will apply toward the out-of-pocket maximum.</td><td colspan="2"><u>Individual</u> <u>Family</u>
<u>In-Network</u> $3,000 $6,200
<u>Out-of-Network</u> $6,000 $12,400

Wellness Center access fees and prescription drug out-of-pocket costs will apply toward the out-of-pocket maximum. (True Family OOP Applies)</td><td colspan="2"><u>Individual</u> <u>Family</u>
<u>In-Network</u> $5,000 $10,000
<u>Out-of-Network</u> $10,000 $20,000</td></tr>
<tr><td>Coordination of Benefits (C.O.B.)</td><td colspan="6">Notre Dame will coordinate with other coverage. The plan will pay based on non-duplication of benefits.
Anthem is primary for you (the employee), and your spouse's employer's insurance plan is always primary for him or her. The two plans "coordinate" benefits for your dependent children. The "birthday rule" determines which plan is primary (pays first) for your dependent children. For example, if the month of your birthday falls <u>before</u> your spouse's birthday month, Anthem will be primary and pay benefits first for your dependents.</td></tr>
</table>

PLAN COVERAGE	ANTHEM - PPO	ANTHEM – HSA 1	ANTHEM – HSA 2
Acupuncture	**In-Network:** 100% after $30 co-payment per physician office visit **Out-of-Network:** Deductible then plan pays 65% Calendar Year Maximum: 20 visits	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65% Calendar Year Maximum: 20 visits	
Allergy Injections	**Primary Care Physician In-Network** 100% after $30 co-payment per physician office visit (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician.) **Specialist Physician In-Network** 100% after $35 co-payment per specialist physician office visit **Out-of-Network:** Deductible then plan pays 65%	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	
Allergy Testing and Serum	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	
Ambulance	**In-Network or Out-of-Network:** Deductible then plan pays 85%	**In-Network or Out-of-Network:** Deductible then plan pays 85%	
Building Healthy Families Program for Expectant Mothers	Building Healthy Families is a program offered by Anthem that offers assistance and guidance for expecting mothers. The plan pays up to $500 in financial incentives to expectant mothers who fill out health assessments during and after their pregnancy.		

PLAN COVERAGE	ANTHEM - PPO	ANTHEM – HSA 1	ANTHEM – HSA 2
Chiropractic Care	**In-Network:** 100% after $30 co-payment per physician office visit **Out-of-Network:** Deductible then plan pays 65% Calendar Year Maximum: 20 visits	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65% Calendar Year Maximum: 20 visits	
Developmental Delay	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	
	Coverage will include: Diagnostic testing, speech therapy, occupational therapy, physical therapy, and education and training office visits for developmental delays. This benefit will cover developmental delays for covered dependents under the age of 5.		
Diabetic Supplies	Diabetic supplies may be covered under pharmacy or durable medical goods coverage. Coverage options are often manufacturer specific.		
Diabetes Education	Calendar Year Maximum: 3 visits		
Doula Services	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	
	Maximum: $2,000 Only covers services associated with the physical birthing process. May require prepayment and manual submission for reimbursement.		
Durable Medical Equipment	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	
Emergency Room Services	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	
	If you have a life threatening medical emergency, you should go to the nearest emergency room for treatment. Those charges will be treated as if they were incurred In-Network.		

PLAN COVERAGE	ANTHEM - PPO	ANTHEM – HSA 1	ANTHEM – HSA 2
Hearing Aids The Plan will not pay for repair of broken, lost aids or for the replacement of batteries	**<u>In-Network or Out-of-Network</u>:** Deductible then plan pays 85% 36 month maximum of $2,500	**<u>In-Network or Out-of-Network</u>:** Deductible then plan pays 85% 36 month maximum of $2,500	
Home Health Care	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65% Calendar Year Maximum: 60 visits	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65% Calendar Year Maximum: 60 visits	
Hospital Room & Board ***Includes Maternity Stays, Mental Nervous and Substance Abuse Disorders***	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
Human Organ Transplants	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
	Recommended use of the Anthem Blue Distinction Program.		
Infertility Testing	Infertility testing is covered by the plan if deemed medically necessary. Some infertility testing and drug therapy may result in non-coverage. Standard benefit levels will apply if treatment is deemed medically necessary.		
Laboratory/X-Ray Services *(Out-patient)*	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
Laboratory/X-Ray Services *When performed 30 days in advance of a physician's office visit and/or 60 days after the physician's office visit. The service must be ordered by the same physician that performed the office visit or the diagnosis must match the one(s) billed by the physician performing the related office visit.*	**<u>In-Network</u>:** 100% - Deductible does not apply **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	

PLAN COVERAGE	ANTHEM - PPO	ANTHEM – HSA 1	ANTHEM – HSA 2
Massage Therapy	**<u>In-Network</u>:** 100% after $30 co-payment per physician office visit **<u>Out-of-Network</u>:** Deductible then plan pays 65% Calendar Year Maximum: 20 visits	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
	Provider must be able to bill insurance. Includes many chiropractic and physical therapy providers.		
Maternity (Prenatal and Postnatal care)	**<u>In-Network</u>:** 100% after $30 co-payment per physician office visit o Copayment shall apply to initial visit only o Services outside the global maternity program fee will be paid at the applicable benefit level **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
Mental Disorders and Substance Abuse Disorders *(Outpatient)* Marital Counseling is covered benefit.	**<u>In-Network</u>:** 100% after $30/$35 co-payment per visit. Depends on specialty **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
Occupational Therapy	**<u>In-Network</u>:** 100% after $30 co-payment per visit **<u>Out-of-Network</u>:** Deductible then plan pays 65% Age 6 and older: prior authorization required before therapy begins. Up to age 5: medical necessity required after 20 visits.	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65% Age 6 and older: prior authorization required before therapy begins. Up to age 5: medical necessity required after 20 visits.	
Physical Therapy *(Doctors Office)*	**<u>In-Network</u>:** 100% after $30 co-payment per visit **<u>Out-of-Network</u>:** Deductible then plan pays 65% Calendar Year Maximum: medical necessity required after 20 visits	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65% Calendar Year Maximum: medical necessity required after 20 visits	

PLAN COVERAGE	ANTHEM - PPO	ANTHEM – HSA 1	ANTHEM – HSA 2
Physical Therapy *(Outpatient)*	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65% Calendar Year Maximum: medical necessity required after 20 visits	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65% Calendar Year Maximum: medical necessity required after 20 visits	
Physician Office Visits *(Co-payments)*	**<u>Primary Care Physician In-Network</u>** 100% after $30 co-payment per physician office visit (Family and General Practitioners, Internist, Pediatrician, or OB-GYN Physician) **<u>Specialist Physician – In-Network</u>** 100% after $35 co-payment per specialist physician office visit **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
Wellness Center Office Visit	$15	$30 access fee **<u>Ancillary Fees:</u>** Deductible then plan pays 85%	
Physician Inpatient Hospital Charges	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
Prosthesis and Orthotic Appliances	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** Deductible then plan pays 85% **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
Preventative & Routine Care Adults and Children	**<u>In-Network</u>:** 100% - Deductible does not apply **<u>Out-of-Network</u>:** Deductible then plan pays 65%	**<u>In-Network</u>:** 100% - Deductible does not apply **<u>Out-of-Network</u>:** Deductible then plan pays 65%	
	Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, pap smears, mammograms, colon exams, sigmoidoscopy, occult blood and PSA testing. School/athletic physical exams are covered as long as they are not billed by the school. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness. Note: Immunizations will be covered in accordance with the following schedules issued by the Health and Human Services Centers for Disease Control and Prevention. United States Recommended Adult & Child Immunization Schedule – United States		

PLAN COVERAGE	ANTHEM - PPO	ANTHEM – HSA 1	ANTHEM – HSA 2
Skilled Nursing Facility	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65% Calendar Year Maximum: 60 days	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65% Calendar Year Maximum: 60 days	
Speech Therapy	**In-Network:** 100% after $30 co-payment per visit **Out-of-Network:** Deductible then plan pay 65% Calendar Year Maximum: 50 visits	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65% Calendar Year Maximum: 50 visits	
Surgery *(Outpatient)*	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	
Surgery *(During a physician office visit)*	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	
TMJ (Temporomandibular Joint Syndrome)	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65% Calendar Year Maximum: $1,000	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65% Calendar Year Maximum: $1,000	
LiveHealth Online Medical (Telehealth)	$15 co-payment	Deductible then plan pays 85%	
Urgent Care Facility	**In-Network:** 100% after $50 co-payment per visit **Out-of-Network:** Deductible then plan pays 65%	**In-Network:** Deductible then plan pays 85% **Out-of-Network:** Deductible then plan pays 65%	
Voluntary Abortion and/or Sterilization	**Not Covered**		
Wisdom Teeth	Coverage for Removal of Impacted Teeth Only	Coverage for Removal of Impacted Teeth Only	

PRESCRIPTION BENEFIT- PPO & HSA

Program Administrated by OptumRx **optumrx.com** 1-866-270-0234

Four tier program with use of preferred drug listing called a formulary

	Participating Retail Pharmacy Up to a 30-day supply	Mail Service Up to a 90-day supply
Generic	$5	$12
Brand formulary	$40**	$80**
Brand non-formulary	$55**	$110**
Specialty drugs	$100	$200 *

* When clinically appropriate

**If a member fills a brand medication that has an equivalent generic version, and the prescriber has not indicated "Dispense as Written", the member will pay the cost difference between the generic and brand medication.

HSA Participants must pay the full cost of a prescription drug until their deductible is met. Upon meeting their deductible, the pharmacy copays above will apply.

What is a formulary?

A formulary is a cost-effective solution to help you with select prescription drugs for you and your family. The formulary is a continually updated list of preferred drugs selected by a panel of physicians and pharmacists. A drug on the formulary list will benefit 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 as 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.

By using the mail service program you can receive up to a 90 day supply of long-term or maintenance medication for less than three months' worth of retail co-payments. Mail service co-payments are as follows: $12 generic, $60 brand, or $90 brand non-formulary. You may also receive up to a 90 day supply of a medication at the Notre Dame Wellness Center Pharmacy for the mail service co-payment rate. This is the only retail location that provides this service.

Special Coverage

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

- Authorizations will be input into OptumRx's system and are good for 12 months.
- No payment will be made for expenses incurred for oral and injectable fertility drugs administered in conjunction with artificial insemination in-vitro fertilization (IVF), GIFT, ZIFT or any other treatment designed to replace normal reproductive processes to achieve pregnancy.

Contraceptives:

- Hormonal contraceptives whose primary purpose is either to prevent ovulation and/or to prevent fertilization will be covered. Those contraceptives that have as their primary function the prevention of implantation or interference with the development of a pregnancy are not covered under the University's plans. Emergency contraceptives are also not covered.

DELTA DENTAL

Delta Dental PPO℠ (Point-of-Service) Group #9541-0001		Delta Dental of Indiana Dental Benefit Highlights for University of Notre Dame DU LAC	Delta Dental PPO℠ (Point-of-Service) Group #5541-0001					
			PPO Dentist		Premier Dentist		Non-Participating Dentist	
Plan Pays	You Pay		Plan Pays	You Pay	Plan Pays	You Pay	Plan Pays	You Pay
		Diagnostic & Preventive						
100%	0%	**Diagnostic and Preventive Services** – exams, cleanings, and fluoride	100%	0%	100%	0%	100%	0%
100%	0%	**Emergency Palliative Treatment** – to temporarily relieve pain	100%	0%	100%	0%	100%	0%
100%	0%	**Brush Biopsy** – to detect oral cancer	100%	0%	100%	0%	100%	0%
100%	0%	**Bitewing Radiographs** – bitewing X-rays	100%	0%	100%	0%	100%	0%
		Basic Services						
50%	50%	**Oral Surgery Services** – extractions and dental surgery	80%	20%	50%	50%	50%	50%
50%	50%	**Endodontic Services** – root canals	80%	20%	80%	20%	50%	50%
50%	50%	**Periodontic Services** – to treat gum disease	80%	20%	80%	20%	50%	50%
50%	50%	**Relines and Repairs** – to bridges and dentures	80%	20%	50%	50%	50%	50%
50%	50%	**Minor Restorative Services** – fillings	80%	20%	50%	50%	50%	50%
50%	50%	**Sealants** – to prevent decay of permanent teeth	80%	20%	50%	50%	50%	50%
50%	50%	**Major Restorative Services** – crowns	Offered Under Major Services					
50%	50%	**Full Mouth Radiographs** – full mouth X-rays	80%	20%	50%	50%	50%	50%
50%	50%	**All Other Radiographs** – other X-rays	80%	20%	50%	50%	50%	50%
		Major Services						
Offered Under Basic Services		**Major Restorative Services** – crowns	50%	50%	50%	50%	50%	50%
50%	50%	**Prosthodontic Services** – bridges and dentures	50%	50%	50%	50%	50%	50%
Not Covered	100%	**Implants** – endosteal implants to replace missing teeth	50%	50%	50%	50%	50%	50%
		Orthodontic Services						
50%	50%	**Orthodontic Services** – braces	50%	50%	50%	50%	50%	50%
No age limit		**Orthodontic Age Limit** –	No age limit					
$1,000		**Maximum Payment** – on all services, except diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants and orthodontic services.	$1,500					
$1,500		The lifetime maximum for each eligible person for Orthodontic Services	$1,500					
$50 individual/$150 family		**Deductible** – The deductible per person total per benefit year limited to a maximum deductible per family per benefit year on Basic Services and Major Services. The deductible does not apply to Diagnostic & Preventive or Orthodontic Services.	$50 individual/$150 family					

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

DELTA DENTAL

DENTAL PLANS								
PLAN COVERAGE	Delta Dental Premier Group #9541-0001				Delta Dental PPO, POS Group #5541-0001			
Dental Premiums per Month for Full time employees	**2024**		**2025**		**2024**		**2025**	
	Individual	$16.74	Individual	$18.10	Individual	$21.36	Individual	$23.10
	Individual + 1	$31.88	Individual + 1	$34.46	Individual + 1	$40.48	Individual + 1	$43.76
	Family	$56.78	Family	$61.80	Family	$74.48	Family	$80.50
Children Eligibility (Due to Age)	Children are eligible up to the age of 26. If a child loses eligibility their coverage will terminate the end of the calendar month in which they lose eligibility.							

Limitations for both 9541 Delta Dental Premier and 5541 Delta Dental PPO (POS)

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable once per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are only payable once per tooth per lifetime for the occlusal surface of first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Crowns, onlays, and substructures are payable once per tooth in any five-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Full and partial dentures are payable once in any five-year period.
- Bridges and substructures are payable once in any five-year period.
- Nitrous oxide is a Covered Service.
- Implants and implant related services are payable once per tooth in any five-year period (Covered under 5541 Delta Dental PPO (POS) plan only.)

Dependent Child(ren) Eligibility - Children up to age 26.

Additional Information

- If enrolling in a dental plan a 2-year commitment is required (may switch dental plans during open enrollment).
- Member ID# is faculty/staff member's NDID.
- Delta Dental Consumer Toolkit – toolkitsonline.com The Consumer Toolkit allows a very secure environment for covered members and their spouses to easily:
    - Verify eligibility of subscriber and dependents;
    - Review up-to-date benefits information (such as how much of your yearly benefit has been used to date, how much is still available to use, and levels of coverage for specific dental services).
    - Review specific claims transactions, reimbursements, and payments; and
    - Print your own member ID cards, Delta Dental does not mail ID cards to you

Print your Dental Insurance Card

1. Visit Delta's website at deltadentalin.com
2. Click on the consumer toolkit on the left hand side in the dropdown box
3. You will need to log-in with your Name, Date of Birth, and Member ID (NDID)
4. Create a username and password
5. After logging in, there will be a link on the left hand side to print your ID card

*Maximum allowable fee is the amount that your dental plan determines is the normal range of payment for a specific service within a given geographic area. If you are using a non-participating dentist, Delta Dental will reimburse you and not the dentist.

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 enrollwitheyemed.com. The network is **Insight**. There are no claim forms to complete for in-network services.

Vision Care Services	In-Network Member Cost	Out-of-Network Allowance
Exam with dilation as Necessary:	$0	Up to $35
Standard Plastic Lenses:		
Single Vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	20% of retail price	Not covered
Retinal Imaging	$15 copay	Allowance up to $20
Frames: Any frame available at provider location	$0 copay, $150 allowance for any frame plus 20% off balance over $150	Up to $65
Lens Options:		
UV Coating	$15	Not covered
Tint (Solid and Gradient)	$15	Not covered
Standard Scratch-Resistance	$15	Not covered
Standard Polycarbonate	$40	Not covered
Standard Progressive-(add-on to Bifocal)	$75	Up to $40
Premium Progressives:		
Tier 1	$95	Up to $40
Tier 2	$105	Up to $40
Tier 3	$120	Up to $40
Tier 4	$75 copay, 80% of charge less $120 allowance	Up to $40
Standard Anti-Reflective	$45	Not covered
Premium Anti-Reflective:		
Tier 1	$57	Not covered
Tier 2	$68	Not covered
Tier 3	80% of charge	Not covered
Other Add-Ons and Services	20% off retail price	Not covered
Contact Lenses:		
Fit and Follow-up (Standard)	Up to $40	Not covered
Fit and Follow-up (Premium)	10% off retail price	Not covered
Conventional	$0 copay, plus 15% discount off balance over $130 allowance	Up to $104
Disposables	$0 copay, plus balance over $130 allowance	Up to $104
Medically Necessary	$0 copay	Up to $210

Laser Vision Correction: Lasik or PRK From US Laser Network	15% of retail price or 5% off promotional price	Not covered
Frequency: Examination Frame Lenses or Contact Lenses	 Once per calendar year Once per calendar year Once per calendar year	 Once per calendar year Once per calendar year Once per calendar year

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

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

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

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

Benefits are not provided for services or materials arising from:

- Refraction when not provided as part of a Comprehensive Eye Examination
- 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
- Safety eyewear unless specifically covered under the plan
- Services provided as a result of any Worker's Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state, or subdivisions thereof
- Plan non-prescription lenses and/or contact lenses and non-prescription sunglasses (except for 20% discount)
- Two pairs of glasses in lieu of bifocals
- Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered and the services rendered to the insured person are within 31 days from the date of such order
- Benefit allowances provide no remaining balance for future use within same benefit period
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except until the next benefit period.

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

VISION PLAN			
Vision Plan	Individual	Individual + 1	Family
EyeMed	$9.72	$18.36	$26.88