MICHIGAN STATE UNIVERSITY
COLLEGE OF LAW

Benefits and Enrollment Guide

June 1, 2014 to May 31,2015

Health | Dental | Life | Disability

HYLANT GROUP

2014 Benefit Summary Guide Overview

MSU College of Law offers eligible employees a variety of benefits that can provide you and your family with health care coverage, financial protection and more, tailored to best fit your needs. Our benefits program is an important part of your overall compensation and with the assistance of HYLANT, we are regularly assessing the quality and cost of the benefits to ensure we offer the most competitive package possible. We encourage you to review this guide in its entirety.

Open Enrollment: Enrollment is only available from May 1, 2014 through May 31, 2014. This is the only opportunity you will have this year to make changes to your benefit elections. During this period you may add, drop, or modify coverage. You will be locked into the plan selections for one year unless there is a qualifying event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status). All changes must be made within 30 days of the event.

Contents

- **Healthcare:** MSU College of Law provides you with the Blue Cross and Blue Shield of Michigan Simply Blue High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). MSU College of Law pre-funds the HSA with your deductible amount. You may contribute additional amounts into the account up to the IRS stated levels. Accounts can be set up with MSU Federal Credit Union.
- **Dental:** MSU College of Law offers you the choice of the Basic Delta or Delta Preferred (PPO) dental plan through Delta Dental. MSU pays for the employee cost. Dependent coverage may be purchased through payroll deduction.
- **Life, AD&D and Long Term Disability:** MSU College of Law provides you with Base Life, AD&D and LTD coverage through Prudential. Additional Term Life and LTD coverage may be purchased through payroll deduction.
- **Short Term Disability:** MSU College of Law provides Staff Employees (only) STD coverage through Prudential.
- **Customer Service Hotline:** In order to help you with your benefit questions, claim issues, and general inquiries, you and your dependents may contact HYLANT. **HYLANT is a one-source helpline for all of your benefit questions. Please call the toll-free number (1-800-609-9614) and speak to a customer service specialist who knows your benefit plan and can help with any questions.**

This booklet is intended for illustrative and information purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern. MSU College of Law reserves the right to change or terminate at any time, in whole or in part, the employee benefit package, with respect to all or any class of employees, former employees and retirees.

Eligibility

MSU College of Law is pleased to offer it's employees an excellent benefit program. These health and welfare benefits are designed to protect you and your family while you are an active employee.

Eligibility: Health and welfare plans are available to all employees who work 30 or more hours per week.

Dependent Eligibility: If you wish, your dependents may also be covered under the medical and dental plans. Eligible dependents include:

- Legal spouse, as defined by Federal Law; and
- Domestic Partner; and
- Your children up to the end of the calendar year when they reach age 26 regardless of marital status, financial dependency, residency with the Eligible Employee, student status, employment status, or eligibility for other coverage.
- It is your responsibility to provide the Human Resources Department with proof of your dependents' eligibility, in the form of: (a) your most recent Federal Income Tax Return, (b) Court Order specifying your responsibility to provide "group health care coverage" to your dependent children, or (c) copy of birth certificate.

New Hire Coverage: As a new hire, your plan eligibility date is the first day of employment with MSU College of Law. Once the necessary enrollment form has been completed, benefits are effective on that date.

New employees have up to 30 days after their eligibility date to enroll. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period.

Annual Elections: It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period. Exceptions will be made for changes in family status during the year, allowing you to make a mid-year benefit change. A family status change includes:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Change in your spouse's employment or
- Loss of coverage by a spouse

If you have a family status change, you must change your benefit elections within 30 days of the qualifying event, or you will need to wait until the next annual open enrollment period.

COBRA Continuation Coverage: When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

Healthcare Benefits At-a-Glance

Healthcare benefits are one of the most important and necessary parts of your benefit package. The following is a summary of your benefits offered through Blue Cross and Blue Shield of Michigan. For a more detailed explanation of benefits, please refer to your certificate of coverage. You may access a list of participating providers at www.bcbsm.com

	BCBSM Simply Blue PPO	
	In-Network *What you pay*	**Out-of-Network** *What you pay*
Doctors Office Visits		
Primary Care Physician	The In-Network Deductible	The Out-of-Network Deductible + 20%
Specialist	The In-Network Deductible	The Out-of-Network Deductible + 20%
Chiropractic	The In-Network Deductible	The Out-of-Network Deductible + 20%
Pre and Post Natal	The In-Network Deductible	The Out-of-Network Deductible + 20%
Preventive Care Services	Covered in Full	Not covered
Urgent Care	The In-Network Deductible	The Out-of-Network Deductible + 20%
Emergency Room	The In-Network Deductible	The In-Network Deductible
Ambulance (medially necessary)	The In-Network Deductible	The In-Network Deductible
Deductible	Per Calendar Year	Per Calendar Year
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance Per Calendar Year	None	20%
Total Out of Pocket Dollar Maximum Per Calendar Year (Including RX Copays)		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Diagnostic Labs & Pathology	The In-Network Deductible	The Out-of-Network Deductible + 20%
Diagnostic Test & X-Rays	The In-Network Deductible	The Out-of-Network Deductible + 20%
In Hospital Charges		
Facility Fees	The In-Network Deductible	The Out-of-Network Deductible + 20%
Professional Fees	The In-Network Deductible	The Out-of-Network Deductible + 20%
Durable Medical Equipment	The In-Network Deductible	The In-Network Deductible
Prosthetic and Orthotic Appliance	The In-Network Deductible	The In-Network Deductible
Out Patient Mental Health		
Facility and Clinic	The In-Network Deductible	The In-Network Deductible
Physicians Office	The In-Network Deductible	The Out-of-Network Deductible + 20%
Prescription Drugs		
Generic Drug	The In-Network Deductible plus $10 Copay per prescription	The Out-of-Network Deductible plus $10 Copay per prescription plus 20% of the approved amount
Brand Name Drug	The In-Network Deductible plus $60 Copay per prescription	The Out-of-Network Deductible plus $60 Copay per prescription plus 20% of the approved amount
Lifetime Maximum Benefit	Unlimited	Unlimited

Dental

The dental coverage is provided by Delta Dental Plan of Michigan. MSU College of Law offers two dental plans for you to choose from, the Delta Premier (Traditional) and the Delta PPO (Point of Service).

The Delta Premier (Traditional) plan offers you the freedom to choose any dentist for your care. Most of the dentists in Michigan are participating with Delta Premier, however, if you receive care from a nonparticipating dentist, you may be billed for the difference between the Delta Dental approved amount and the dentist's actual charge.

The Delta PPO (Point of Service) plan offers offer you the freedom to choose any dentist for your care. However, you will experience a higher level of benefits and less out of pocket cost when you seek services from a Delta Preferred dentist. With the flexibility of a PPO you have the option of visiting any provider, however, by choosing a network provider you'll receive the highest level of benefit and save on out of pocket costs. When utilizing ***out-of-network providers*** remember that benefits will be reimbursed at the in-network discounted reimbursement level. For example, if you have a procedure done that costs $80 and the in-network reimbursement level is $60, your reimbursement will be based on $60, and you will be responsible for the difference (in this case, $20).

	Basic Plan	PPO Plan	
	In-Network What you pay	In-Network What you pay	Out-Of-Network What you pay
Preventive Services (Cleanings, Fluoride Treatment for Children, Emergency Palliative, Xrays)	The Deductible + 20% (X-Rays covered under Basic Services)	Covered In Full	20% of the R&C fee
Basic Services (Restorative, Endodontics, Periodontics, Oral Surgery, Fillings)	The Deductible + 50%	The Deductible + 20%	The Deductible + 50% R&C
Major Services (Crowns, Bridges, Dentures)	The Deductible + 50%	The Deductible + 50%	50% after deductible
Deductible (June – May)			
Individual	$25	$25	
Family	$75	$75	
Maximum Annual Benefit (June – May)	$1,000	$1,000	
Orthodontics	Not covered	50% Lifetime maximum: $1,000	

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Life and Accidental Death & Dismemberment (AD&D)

Life and Accidental Death & Dismemberment (AD&D) Insurance is provided by Prudential at no cost to the employee. Life Insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at MSU College of Law. AD&D Insurance is equal to your Life Insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances. It is important to keep your beneficiary information up-to-date. Please refer to your benefit booklet for more details.

Plan Features	Benefit Amount
Employee Life and Accidental Death & Dismemberment Insurance	100% of your Basic Annual Earnings up to $400,000
Spouse Life Insurance	$2,000
Dependent Child(ren) Life Insurance	Children age 14 days or over but less than 6 months: $100 Children over 6 months: $1,000

Optional Life Insurance

Employees have the opportunity to elect voluntary Life Insurance. This will provide an additional Life Insurance benefit for yourself, your spouse and/or your dependent child(ren). Contributions for these premiums are 100% employee paid. *If you waive voluntary life coverage when you are initially eligible you will be required to provide Evidence of Insurability when enrolling at a later date.* Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results. It is important to keep your beneficiary information up-to-date.

Plan Features	Benefit Amount
Employee Life Insurance	Available in increments of $25,000, $100,000 or $200,000. Basic and Optional Life amounts cannot exceed combined $400,000. (Evidence of Insurability is required for Basic and Optional combined coverage in excess of $200,000)
Spouse Life Insurance	$15,000
Dependent Child(ren) Life Insurance	Children age 14 days or over but less than 6 months: $500 Children over 6 months: $10,000

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Short Term Disability (Staff Employees Only)

Short Term Disability Insurance is provided to Staff Employees by Prudential at no cost to the employee. Short Term Disability Insurance provides income protection in the event you become disabled and are unable to work due to sickness or non-occupational injury, including pregnancy, for a short period of time.

Short Term Disability Benefit Summary	
Benefit Amount	66 2/3 % of Weekly Earnings
Benefit Maximum	$200 per Week
Elimination	30 Days
Maximum Benefit Period	22 Weeks Per Disability

Long Term Disability

The Base Long Term Disability Insurance is provided by Prudential at no cost to the employee. Long Term Disability Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time. Any benefit paid out will be subject to income taxes. You do have the option to pay for the Base Long Term Disability through payroll deduction which would make this a tax-free benefit.

Base Long Term Disability Benefit Summary	
Benefit Amount	60% Monthly Earnings
Benefit Maximum	$15,000 per Month
Benefit Duration	To Normal Social Security Age
Elimination Period	180 Days
Definition of Disability	You are unable to perform the material duties of your regular occupation due to your sickness or injury or you are unable to earn 80% or more of your Indexed Earnings from working in your regular occupation.

Optional Long Term Disability

You may elect to purchase Optional LongTerm Disability Insurance which will increase your covered earnings from 60% to 70%. *If you waive optional disability coverage when you are initially eligible you will be required to provide Evidence of Insurability when enrolling at a later date.* Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results.

Optional Long Term Disability Benefit Summary	
Benefit Amount	70% Monthly Earnings
Benefit Maximum	$15,000 per Month
Benefit Duration	To Normal Social Security Age
Elimination Period	180 Days
Definition of Disability	You are unable to perform the material duties of your regular occupation due to your sickness or injury or you are unable to earn 80% or more of your Indexed Earnings from working in your regular occupation.

Health Savings Account (HSA)

If you are enrolled in the medical plan you are eligible to open a HSA account with MSU Federal Credit Union. HSA's are tax saving tools. Here are some things you should know:

- You must be covered by a High Deductible Health Plan to be eligible.
- You can contribute up to $3,300 /$6,550 (single/ family) for 2014 by payroll deduction or by writing a check. Your contributions are tax deductible. You can even make a one-time transfer from your IRA. Contributions can be made until April 15 of the following year. Those 55 or over can contribute $1,000 more.
- The money in your account is yours, and may earn interest until you use it. Money comes out tax free for eligible healthcare expenses.
- You do not need to submit expenses for reimbursement; it is up to you to use the money appropriately. We are all subject to an IRS audit...the penalty for using ineligible HSA money in 2013 is 20 percent.
- You can always find the most up-to-date list of qualifying expenses online, in Publication 502 on the IRS website (www.irs.gov) Below are a sampling of qualifying expenses:
    - Long-term care (medical expenses and insurance)
    - Nursing services
    - Medical doctors
    - Physical Therapy
    - Christian Science practitioners
    - Psychoanalysis
    - Emergency care
    - Chiropractic care
    - Acupuncture

Use for treatments not covered by insurance:

- Dental care including dentures
- Medical equipment, appliances and other personal items
- Vision care including eyeglasses, contact lenses and eye surgery
- Alcoholism or drug addiction treatment
- Fertility treatment
- Over the counter medications (with prescription)
- Hearing aides
- Prescribed weight-loss or stop-smoking programs
- Trips/travel exclusively for a treatment
- Special schools/homes for mentally retarded

What Expenses Do NOT Qualify?

These expenses are just a sampling of expenses you can't pay for with your HSA. (Remember, most over the counter medications are no longer eligible without a prescription.)

- Cosmetic surgery
- Diaper services
- Teeth whitening
- Electrolysis for hair removal
- Maternity clothes
- Household help or babysitting
- Health club dues
- Food supplements not prescribed by a doctor
- Hair transplants
- Swimming lessons
- Marijuana for glaucoma
- Over-the-counter vitamins or diet drinks
- Weight-loss programs not prescribed

Dependent Coverage & Your HSA

The Company plan allows for employees to elect coverage for their dependents to age 26; however the money in the employee's HSA account may only be used for eligible expenses incurred by covered dependents that meet the IRS definition of a tax dependent. If you list a dependent on your federal income tax return, then you can use the money in your HSA account for the eligible expenses. When an adult dependent child does not qualify as a tax dependent, then any HSA distributions for the child would be taxable and subject to IRS penalty.

Flexible Spending Accounts (FSA)

All eligible employees will have the opportunity to participate in a Flexible Spending Account (FSA) program administered through Infinisource.

Employees enrolled in the Medical plan with a Health Savings Account (HSA) may enroll in a Limited FSA . A Limited FSA only allows reimbursement for dental and vision expenses. Medical expenses are covered by the HSA.

What is a Flexible Spending Account?

A Flexible Spending Account, also known as Section 125 Cafeteria Plan, allows participants to set aside pre-tax dollars to be used to pay for various out of pocket medical, dental and vision expenses, and dependent care expenses.

What are the types of FSAs?

There is one for medical, dental and vision expenses. You can use this account to pay for medical, dental and vision expenses that you or your dependents incur even if they are not enrolled in the company sponsored medical plan. You also have a Dependent Care flexible spending account. This account is for DAYCARE expenses ONLY & cannot be used for medical expenses.

How Does an FSA work?

First, you must estimate the amount of out-of-pocket expenses you feel you may incur in the upcoming year. This amount will be your election amount. Your election amount is divided by the frequency of pay periods. This amount is then deducted from your paycheck each pay period on a pre -tax basis. When you incur expenses during the plan year, simply submit a reimbursement form with the receipt(s) to Infinisource for reimbursement. . The amount of your expense will be deducted from your account balance.

What is the Plan year?

January 1 through December 31

The Use It or Lose It Rule

Section 125 Plans are governed by the “use it or lose it” rule, whereby, any amounts remaining at the end of the year are forfeited due to IRS regulations. **All claims must be submitted no later than 90 days after the end of the plan year.**

	Without Flex Plan	With Flex Plan
Salary	$700	$700
FSA Election	$0	$25
Taxable Income	$700	$675
Income Tax	$105	$101
State Tax	$56	$54
Social Security Tax	$53	$51
Income After Taxes	$486	$469
Medical Premium	$10	
Medical Expenses	$5	
Dependent Care	$10	$0
Take Home Pay	$461	$469
Net Increase		$8
Pay Periods		x 52
Annual Increase		$416

How Much Can I Contribute to the FSA Plan?

Medical Flexible Spending: **$2,500 Maximum**.
Dependent Care Flexible Spending: **$5,000 married couple filing jointly ($2500 per person if filing separate returns).**

Medical FSA Overview

There are at least two significant ways to benefit from a Flexible Spending Account. The first is by taking advantage of the tax savings. By reducing your gross income, you pay less in taxes, take home more pay, and have the freedom to choose how your money is used.

The second benefit is the "cash flow" increase built into the medical FSA (not the dependent day care FSA). This means that no matter how much money you have actually contributed to the plan at any given point, you can still be reimbursed up to your entire annual election. So a major medical expense at the beginning of the claim period can be reimbursed even though few, if any, deposits have been made into the account at that time. This applies to the medical FSA only.

Medical FSA Claims Reimbursement

Through Infinsource, you have a variety of ways to choose from to get reimbursed for your claims: fax, email, mail.

Fax, Email or Mail

You are able to submit your claims via fax at 800-379-5670, by email fsa@infinisource.com or by mail at: Infinisource, PO Box 488, Coldwater, MI 49036.

Sample Medical Eligible Expenses

The following is a partial list of expenses that are reimbursable tax-free with a Medical Expense FSA. For a complete list, visit the IRS's website at www.irs.gov and search for Section 213 expenses.

- Acupuncture (if medically necessary)
- Ambulance service
- Chiropractic care
- Contact lenses (corrective)*
- Diagnostic tests
- Doctor's fees
- Drugs (prescription only**)
- Experimental medical treatment (only if referred by a physician)
- Eyeglasses
- Hearing aids & exams
- Injections and vaccinations
- Optometrist fees
- Orthodontic treatment*
- Prescription drugs to alleviate nicotine withdrawal symptoms
- Smoking cessation programs/treatments
- Transportation for local medical care
- Wheelchairs
- X rays

**To be eligible for reimbursement, some treatments, prescription drugs, or services deemed cosmetic in nature require written proof of medical necessity from your health care provider.*

***Not all drugs requiring a prescription are approved by the IRS as eligible for reimbursement.*

Dependent Eligible Expenses

Below is a list of expenses that qualify for reimbursement from the Dependent Care Account. Generally, eligible expenses include the cost of childcare for dependents under age 13 or care for a disabled spouse or dependent that allows you – or you and your spouse – to work. You'll also find examples of expenses that do not qualify for reimbursement because they are not considered legitimate deductions for federal income tax purposes. To make sure your situation and the type of care being provided meet IRS requirements, refer to IRS Publication 503.

Eligible Expenses

- Fees paid to a child care center or day care camp that complies with all applicable state and local regulations if providing care for more than six children
- Full amount paid to a nursery school, even though the cost may include lunch and education services
- Fees paid to a babysitter in or outside your home
- Fees paid to a relative who provides dependent care services, other than your spouse, your child under age 19 or a dependent you claim for federal income tax purposes
- Fees paid to a housekeeper or cook who also is responsible for providing care for an eligible dependent
- Fees paid to a nurse or home health care agency for care for your spouse or legal dependent who is physically or mentally incapable of self-care
- Legally mandated amounts paid on behalf of the provider – Social Security (FICA), federal (FUTA) and state (SUTA) unemployment taxes

Ineligible Expenses

- Food, clothing and education
- Transportation to and from the place where dependent care services are provided
- Fees paid for a child care center that provides care for more than six children but does not comply with all applicable laws
- Expenses for which a federal child care tax credit is taken or which are claimed under the Health Care Account
- Search fees for a dependent care provider

Section 125 Cafeteria Plan

The Section 125 - Cafeteria Plan allows you to contribute "before-tax" dollars to pay for your coverage under a portion of the Company's Benefit Plans (e.g. medical, dental and vision coverage). By paying your premiums with "before-tax" dollars, you generally may reduce the amount of income and social security taxes that you otherwise would be required to pay. The elections you make during the Cafeteria Plan enrollment period are effective for the entire 12-month Plan Year. You generally cannot change your elections during the year unless you experience a change in status event (refer to your benefits booklet for the definition of a "change in status"). The circumstances that permit a change of election vary from one benefit to another. If you believe you have experienced a change in status event and you wish to change your elections, notify HR within 30 days of the change.

Important Disclosures

NOTE TO ALL EMPLOYEES:

Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

MSU College of Law
Human Resources
648 North Shaw Lane
Room 364
East Lansing, MI 48824
517-432-6998

THIS DOCUMENT IS FOR INFORMATION PURPOSES ONLY

This communication is intended for illustrative and information purposes only. The plan documents, insurance certificates, and policies will serve as the governing documents to determine plan eligibility, benefits, and payments.

LIMITATIONS AND EXCLUSIONS

Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

ALL RIGHTS RESERVED

MSU College of Law reserves the right to amend, modify, or terminate its insurance and benefit plans at any time, including during treatment.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.

(a.) If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Medical Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

(1.) Your or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

(d.) You are eligible to enroll yourself and your Eligible Dependents in the Plan during an Open Enrollment Period. Your enrollment will become effective on the 1st day of the Plan Year following the Open Enrollment Period.

(e.) You may enroll in the Plan an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.

(f.) You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permitted under the applicable Benefits Guide (and subject to the Cafeteria Plan rules outlined in Section 125 of the Internal Revenue Code).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for

Important Disclosures

a dependent under the age of 26; or within the deadline established by the Plan Administrator for Open Enrollment Period).

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

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Human Resources
648 North Shaw Lane
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NOTICE REGARDING PRE-EXISTING CONDITIONS

The MSU College of Law Group Health Plan (the "Plan") does not impose a pre-existing condition limitation as detailed in the Benefit Guide issued by the insurance carrier. Please review the Benefits Guide carefully (you can obtain another copy of it by contacting the Plan Administrator). The following provides an overview of the preexisting condition limitation that is allowed under the Health Insurance Portability and Accountability Act (HIPAA) as well as protections provided under the Patient Protection and Affordable Care Act of 2010 (PPACA). If the Plan does not impose a pre-existing condition limitation, much of this information does not apply to you; however, this information is provided to make you aware of this important legislation.

The Plan complies with the changes set forth in the PPACA of 2010 and does not impose pre-existing condition exclusions with respect to eligible dependent children who are under 19 years of age. In accordance with PPACA, this change was effective as of the first day of the Plan Year beginning on or after September 23, 2010; and will apply to all other covered individuals on the first day of the Plan Year beginning on or after January 1, 2014.

Pre-existing condition exclusion means that if you have a medical condition before enrolling in the medical program, you might have to wait a certain period of time before the medical program will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month look-back period. Generally, this 6 -month period ends the day before your coverage becomes effective. However, if you were in a new hire waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the medical program or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. **To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should promptly give the Plan Administrator a copy of any certificate of creditable coverage (HIPAA Certificates) you have**. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or insurer. There are also other ways that you can show that you have creditable coverage. Please contact the Plan Administrator if you need help demonstrating creditable coverage.

Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator (with the assistance of the prior plan administrator or insurer) to determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment, and may result in a loss of coverage under this Plan and other employment disciplinary action.

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN:

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card. If you are unable to obtain the certificate of coverage through the carrier, or have other questions regarding Pre-existing Conditions, please contact the Plan Administrator for assistance at the address or phone number below.

June 1, 2014

MSU College of Law
Human Resources
648 North Shaw Lane
Room 364
East Lansing, MI 48824
517-432-6998

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health

Important Disclosures

plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

MEDICARE NOTICE

You must notify MSU College of Law when you or your dependents become Medicare eligible. MSU College of Law is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other then the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

June 1, 2014
MSU College of Law
Human Resources
648 North Shaw Lane
Room 364
East Lansing, MI 48824
517-432-6998

NOTICE REGARDING PATIENT PROTECTION RIGHTS

The MSU College of Law group health plan does not require members to designate a Primary Care Physician. The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician.

Important Disclosures

One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

June 1, 2014

MSU College of Law
Human Resources
368 Law College Bldg
Room 364
East Lansing, MI 48824
517-432-6800

IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with MSU College of Law and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. MSU College of Law has determined that the prescription drug coverage offered by their carrier's Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the cover-

age provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact your HR Representative. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit Social Security at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a coy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are require to pay a higher premium (penalty).

June 1, 2014
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Important Disclosures

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2011. You should contact your State for further information on Eligibility:

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-800-362-1504

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants/default.aspx
Phone (Outside Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602.417.5437

ARKANSAS – CHIP
Website: http://www.arkidsfirst.com/
Phone: 1-888-474-8275

COLORADO – Medicaid and CHIP
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In State): 1-800-866-3513
Medicaid Phone (Out of State): 1-800-221-3943
CHIP Website: http:// www.CHPplus.org
CHIP Phone: 303-866-3243

CALIFORNIA – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-866-298-8443

FLORIDA – Medicaid
Website: http://www.flmedicaidtplrecovery.com
Phone: 1-877-357-3268

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/OIAS/publicassistance/index.html
Phone: 1-800-572-3839

MASSACHUSETTS – Medicaid and CHIP

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

INDIANA – Medicaid
Website: http://www.in.gov/fssa/2408.htm
Phone: 1-800-889-9948

KANSAS – Medicaid
Website: https://www.kdheks.gov/hcf
Phone: 800-792-4884

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Important Disclosures

STATES OFFERING PREMIUM PAYMENT ASSISTANCE PROGRAMS CONTINUED

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone (Outside of Twin City area): 1-800-657-3739
Phone (Twin City area): 651.431.2670

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.dhhs.ne.gov/med/medindex.htm
Phone: 1-877-255-3092

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/ombp/index.htm
Phone: 603-271-8183

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW MEXICO – Medicaid and CHIP
Medicaid & CHIP Website: http://www.hsd.state.nm.us/mad/index.html
Medicaid & CHIP Phone: 1-888-997-2583
Click on Insure New Mexico

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.nc.gov

OREGON – Medicaid and CHIP
Medicaid & CHIP Website:
http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml
Medicaid & CHIP Phone: 1-888-564-9669

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.dhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH– Medicaid
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT– Medicaid
Website: http://www.greenmountaincare.org
Telephone: 1-800-250-8427

VIRGINIA– Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms
Phone: 304-558-1700

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

To see if any more States have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
OMB Control Number 1210-0137

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Blue Cross Blue Shield Pharmacy Initiatives

Did you know that the average cost of a prescription brand-name drug is $140 while the average cost of a generic drug is approximately $15? Keeping prescription drug costs affordable continues to be a major focus at Blue Cross Blue Shield of Michigan. The initiatives listed below are part of your prescription drug plan and are designed to minimize your out-of-pocket costs while providing you with the same level of coverage and clinically sound alternatives. We encourage you to talk with your physician about your medications and decide if a generic equivalent, generic alternative, or an over-the-counter medication may be a good choice for you. For more information, please visit **www.bcbsm.com** and click on *Prescription Drugs*.

Member Education Therapeutic Interchange

A member-directed initiative that educates you about generic drugs and over-the-counter equivalents of expensive brand-name medicine.

Added Value

Lowers your out-of-pocket copays. Helps you learn about generics and OTC alternatives with the same effectiveness as more expensive brand-name drugs.

How it Works

- The first time you have a prescription filled and the drug is part of this initiative, BCBSM will contact you and your physician encouraging the prescribing of a lower-cost alternative or OTC medicine for the prescription you are taking.
- If you and your physician choose to switch to the recommended drug, then your first prescription is free because BCBSM will waive your copay: *If you are switching to an OTC alternative, your physician will give you a new prescription for the drug.*
- If you choose not to switch to the recommended drug, then you can continue taking the brand-name drug for up to 90 days. After 90 days: *Your physician must call BCBSM to provide evidence of medical necessity. If evidence of medical necessity is not approved, then you will be responsible for the cost of the brand-name drug.*

Dose Optimization

A physician-directed initiative that encourages your physician to consider a dosing regimen of once per day, instead of smaller doses throughout the day.

Added Value

Studies show people taking one pill each day (instead of multiple pills) can increase their compliance with drug therapy. For some medications, you could see a cost savings of up to 50% per refill.

How it Works

- If you have a prescription filled and the drug is part of this initiative, BCBSM will contact your physician encouraging the prescribing of a once-per-day regimen.
- If your physician chooses to switch you to this daily regimen, you will receive a letter notifying you of the change with instructions for your next visit to the pharmacist.

Brand to Alternate Generic Interchange

A physician-directed initiative that encourages the replacement of brand-name drugs with less-costly generic alternatives.

Added Value

In most cases, lowers your out-of-pocket copays. Helps you learn about lower-cost generics and generic alternatives with the same effectiveness as more expensive brand-name drugs.

How it Works

- If you have a prescription filled and the drug is part of this initiative, BCBSM will contact your physician encouraging the prescribing of a less-costly generic equivalent or alternative.
- If your physician chooses to switch you to a generic alternative, BCBSM will send you a letter and your physician will provide you with a new prescription.

Brand to Brand Therapeutic Interchange

A physician-directed initiative designed to encourage the replacement of targeted high-cost drugs with lower-cost branded drugs equal in strength and efficiency.

Added Value

Lowers your copay if you have a percent or triple-tier benefit plan.

Blue Cross Blue Shield Pharmacy Initiatives

How it Works

- If you have a prescription filled and the drug is part of this initiative, BCBSM will contact your physician encouraging the prescribing of a less-costly brand alternative.
- If your physician chooses to switch you to a lower-cost brand drug, BCBSM will send you a letter and your physician will provide you with a new prescription.

Three-Month Generic Copay Holiday

For retail or mail-order prescriptions, your first three copays will be waived if you switch from a targeted, **cholesterol-lowering** brand-name drug to a generic equivalent or alternative.
Added Value
Lowers your out-of-pocket costs. Helps you learn about lower-cost generics and alternatives with the same effectiveness as more expensive brand-name drugs.
How it Works

- The first time you have a prescription filled and the drug is part of this initiative, BCBSM will send a letter encouraging you to discuss less-costly generic equivalents with your physician.
- If you and your physician agree to switch to a generic equivalent, BCBSM will cover the cost of your normal copay for your first three retail or mail order prescriptions:

For generic equivalents, tell your pharmacist that you would like the generic form of the prescription. If you switch to a generic alternative, your physician will provide you with a new prescription for the drug.

Preferred Therapy

A program that targets certain brand-name drugs so that the first time you fill a new prescription for a medical condition, you start with the generic alternative(s) and then, when medically appropriate and with prior authorization you would receive the brand-name drug.
Added Value
Lowers your out-of-pocket costs. Helps you learn about lower-cost generics and generic alternatives with the same effectiveness as more expensive brand-name drugs.
How it Works

- The first time you have a prescription filled for a targeted drug, your physician must be contacted to see if the drug therapy for your medical condition can be changed to a generic equivalent or alternative.

If your physician requests the brand-name be dispensed, he or she must request prior authorization from BCBSM.

Quantity Limits

Initiative that restricts dispensing of targeted drugs in quantities not consistent with FDA-approved labeling or published clinical criteria for the drugs.
Added Value
Helps to ensure you are using your medication appropriately. Designed to limit the use of selected drugs for quality and safety reasons.
How it Works

- If you have a prescription filled and the drug is part of this initiative, the pharmacist will only fill your prescription for the quantity limit approved for the drug.
- For quantities greater than the recommended amount, your physician must call BCBSM and provide evidence of medical necessity: *If evidence of medical necessity is not approved, then your pharmacist will only fill your prescription to the quantity limit approved for the drug.*

Generic Copay Waiver

A one-time waiver if you switch from a targeted brand-name drug to a generic equivalent, generic alternative or preferred brand drug.
Added Value
Lowers your out-of-pocket costs. Helps you learn about lower-cost generics and alternatives with the same effectiveness as more expensive brand-name drugs.
How it Works

- The first time you have a prescription filled and the drug is part of this initiative, BCBSM will send you a letter encouraging you to discuss with your physician or pharmacist less-costly generic equivalents or alternatives.
- If you and your health care provider choose to switch to a generic equivalent or alternative, then

your first prescription is free because BCBSM will waive your copay: *For generic equivalents, tell your pharmacist that you would like the generic form of the prescription. If you switch to a generic alternative, your physician will provide you with a new prescription for the drug.*

Exclude Off-Label Coverage

Initiative that requires medical necessity for drugs prescribed for uses other than those approved by the FDA.

Added Value

Ensures you are using medication appropriately and safely.

How it Works

- If your physician is prescribing a medication for a purpose for which they are not intended, such as growth hormones for anti-aging purposes, then your physician must call BCBSM to provide evidence of medical necessity for the prescription. If evidence of medical necessity is not approved, then you will be responsible for the cost of the prescription.

Enhanced Polypharmacy Outreach and High-Utilization Management

A physician-directed initiative intended to provide physicians with prescription drug usage information to identify and monitor potential misuses and excessive use of prescription drugs.

Added Value

Helps prevent and protect you against adverse drug reactions by alerting your physician of potentially dangerous situations.

How it Works

- This initiative helps us provide better care for our members by alerting your physician to potentially harmful situations that can occur if you are being treated for multiple conditions or being treated by multiple physicians.

BCBSM Value-Added Services

Blue Cross Blue Shield and Blue Care Network of Michigan can help you save money. Some of the ways we're helping to keep health care costs low include:

- **Blue365:** offers you big savings and discounts on weight loss programs, gym memberships, travel and family care featuring great companies such as Curves®, Gold's Gym® and Snap Fitness.
- **BlueSafe** is an injury prevention program for Blue Cross Blue Shield and Blue Care Network of Michigan members. Show your Blues identification card to save 20 percent at Michigan Dunham's Sports for safety items like helmets and padding for bicycles, in-line skates and scooters, athletic braces and supports, and life jackets. Members also save 20 percent at Michigan Wright & Filippis stores on all home medical equipment not covered by their health coverage, including bathroom safety seats, grab bars and first aid kits.
- **BlueSafe** also entitles our members to a 10 percent discount at Michigan Dunham's Sports on all regularly priced merchandise, excluding firearms, ammunition, licenses, trading cards, DVD's, Scout merchandise, select Nike products, Under Armour products, gift cards, gift certificates and special order items. This offer cannot be combined with any other offer or used on the Dunham's Web site.
- **Naturally Blue℠**: Blues members can obtain complementary health services at a discount. Our Naturally Blue program includes services such as Acupuncture, Exercise/Movement, Diet and Supplement Advisors, Massage and Bodywork, Mind/Body Relaxation Techniques, Wellness/Fitness Centers, Reference Library, Magazine Subscriptions, and much more.
- **Weight Watchers®** By showing their identification cards, members receive a **discount on Weight Watchers membership fees**.

Blues members in these counties pay:

- $138 for the Traditional 12-week program — 25 percent off the published rate
- $135 for the At Work program* — 10 percent off the published rate

Show your Blues ID card at your first meeting to receive your discounted rate. Call 888-3-Florine or go to 888-3-Florine.com to find your Florine Mark Weight Watchers location. *Minimum enrollment required for the At Work program.

- **E-Diets:** 25% off any online diet or 15% off the eDiets Meal Delivery program. Go to www.ediets.com.
- **Jenny Craig:** Join Jenny Craig and receive a 30 FREE 30 day program (does not include the cost of food) www.JennyCraig.com
- **Healthy Reading Discounts**: You can get substantial savings on subscriptions to health and wellness magazines. Savings anywhere from 45%-76% off the newsstand price.
- **Practitioner Discount:** Great discounts from acupuncture to massage
- **Vitamin Discounts:** Receive significant discounts on vitamins natural supplements

Log onto www.BCBSM.com for more information.

Insurance Definitions

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A **copayment**, or **copay**, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it be payment, denial, or pending) to a medical claim processed on your behalf.

IN NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAIL ORDER PRESCRIPTIONS: Used as an alternative to retail pharmacies, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma.

MAXIMUM OUT OF POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Depending on the policy, it may or may not include charges applied to the deductible and copays.

OPEN ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

OUT OF NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

Contact Information

Health Care	Blue Cross Blue Shield	1-800-637-2227	www.bcbsm.com
Dental	Delta Dental of MI	1-800-482-8915	www.ddpmi.com
Life AD&D **Short Term Disability** **Long Term Disability**	Prudential	1-888-598-5671	www.prudential.com
Health Savings Account	MSU Federal Credit Union	1-800-678-4968	www.msufcu.org/hsaservicecenter
Flexible Spending Accounts	Infinisource	1-800-300-3838	www.infinisource.com
Broker	Hylant Group	1-800-609-9614	www.hylant.com

When contacting any of the companies above it is important to have the Insurance card or I.D. number (s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, i.e. Explanation of Benefits, denial letter, receipts, etc.

Benefit Summaries

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Simply Blue[SM] PPO HSA LG with Prescription Drugs Benefits-at-a-Glance

MSU College of Law 007001147-0006

Effective for groups on their plan year beginning on or after January 1, 2014

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible, copay and /or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

	In-network	Out-of-network *
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$2,000 for a one-person contract or $4,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)	$4,000 for a one-person contract or $8,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount for most covered services
Annual out-of-pocket maximums – applies to deductibles and coinsurance amounts for all covered services – including prescription drug cost-sharing amounts	$3,000 for a one-person contract or $6,000 for a family contract (2 or more members) each calendar year	$6,000 for a one-person contract or $12,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

* Services from a provider for which there is no Michigan PPO network and services from a out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network *
Preventive care services		
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

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	In-network	Out-of-network *
Physician office services		
Office visits – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Emergency medical care		
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services – must be medically necessary	100% after in-network deductible	100% after in-network deductible
Diagnostic services		
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible
Maternity services provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% after in-network deductible	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	100% after in-network deductible	100% after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	100% after in-network deductible	100% after in-network deductible

* Services from a provider for which there is no Michigan PPO network and services from a out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network *
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	100% after in-network deductible	80% after out-of-network deductible
Human organ transplants		
Specified human organ transplants – must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible – in designated facilities **only**
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible
Mental health care and substance abuse treatment		
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible, in participating facilities **only**
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. ABA and AAEC services are not available outside of Michigan.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is limited to the same annual **combined** limit as for physical, speech and occupational therapy for other diagnoses	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from a out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network *
Other covered services		
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year (visits are **combined** with therapies for autism spectrum disorder)	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	100% after in-network deductible

See Prescription Drug Coverage Benefits-at-a-Glance for prescription drug benefits.

* Services from a provider for which there is no Michigan PPO network and services from a out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

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Simply Blue[SM] PPO HSA LG Benefits-at-a-Glance

MSU College of Law 007001147-0006

Effective for groups on their plan year beginning on or after January 1, 2014

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Specialty Pharmaceutical Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum:

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

		90-day retail network pharmacy	*** In-network mail order provider**	**In-network pharmacy** (not part of the 90-day retail network)	**Out-of-network pharmacy**
Generic or **select** prescribed over-the-counter drugs	1 to 30-day period	$10 copay	$10 copay	$10 copay	$10 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$20 copay	No coverage	No coverage
	84 to 90-day period	$20 copay	$20 copay	No coverage	No coverage
Brand-name drugs	1 to 30-day period	$60 copay	$60 copay	$60 copay	$60 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$120 copay	No coverage	No coverage
	84 to 90-day period	$120 copay	$120 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

***** BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

	90-day retail network pharmacy	*** In-network mail order provider**	**In-network pharmacy** (not part of the 90-day retail network)	**Out-of-network pharmacy**
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs – when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements, and vitamins	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements, and vitamins	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug ***plus*** an additional 20% prescription drug out-of-network penalty

***** BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug, It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com/pharmacy**, **along with the preferred medications**. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.

Blue Cross Blue Shield of Michigan

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 01/01/2014

Coverage for: Individual/Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsm.com or by calling the number on the back of your BCBSM ID card.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$2,000 Individual/ $4,000 Family	$4,000 Individual/ $8,000 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.		You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses? (May include a co-insurance maximum)	$3,000 Individual/ $6,000 Family	$6,000 Individual/ $12,000 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.		The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.bcbsm.com or call the number on the back of your BCBSM ID card.		If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.		You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.		Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Group Number 007001147-0006

Questions: Call the number on the back of your BCBSM ID card or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number on the back of your BCBSM ID card to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge after deductible	20% co-insurance after deductible	---none---
	Specialist visit	No Charge after deductible	20% co-insurance after deductible	---none---
	Other practitioner office visit	No Charge for Chiropractic and osteopathic manipulative therapy	20% co-insurance after deductible for Chiropractic and osteopathic manipulative therapy	Limited to a combined maximum of 24 visits per member per calendar year for chiropractic and osteopathic manipulative therapy
	Preventive care/ screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	20% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	20% co-insurance after deductible	---none---
If you need drugs to treat your illness or condition Some plans may have a separate out of pocket maximum for prescription drug coverage, for more information please contact your plan administrator	Generic or prescribed over-the-counter drugs	$10 co-pay for retail 30-day supply; $20 co-pay for retail or mail order 90-day supply	In-Network co-pay plus an additional 20% of the BCBSM approved amount for the drug	For information on women's contraceptive coverage, contact your plan administrator. 90-day supply not covered out-of-network. Specialty drugs limited to a 30-day supply per fill.
	Formulary (preferred) brand-name drugs	$60 co-pay for retail 30-day supply; $120 co-pay for retail or mail order 90-day supply.	In-Network co-pay plus an additional 20% of the BCBSM approved amount for the drug	Specialty drugs limited to a 30-day supply per fill
	Nonformulary (nonpreferred) brand-name drugs	$60 co-pay for retail 30-day supply; $120 co-pay for retail or mail order 90-day supply.	In-Network co-pay plus an additional 20% of the BCBSM approved amount for the drug	Specialty drugs limited to a 30-day supply per fill

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fees	No Charge after deductible	20% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room services	No Charge after deductible	No Charge after deductible	---none---
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	---none---
	Urgent care	No Charge after deductible	20% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fee	No Charge after deductible	20% co-insurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge after deductible	50% co-insurance after deductible	---none---
	Mental/Behavioral health inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Substance use disorder outpatient services	No Charge after deductible	50% co-insurance after deductible	---none---
	Substance use disorder inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
If you are pregnant	Prenatal and postnatal care	Prenatal: No Charge Postnatal: No Charge after deductible	20% co-insurance after deductible	---none---
	Delivery and all inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	No Charge after deductible	---none---
	Rehabilitation services	No Charge after deductible	20% co-insurance after deductible	Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	No Charge after deductible for Applied Behavioral Analysis; No Charge after deductible for Physical, Speech and Occupational Therapy	No Charge after deductible for Applied Behavioral Analysis; 20% co-insurance after deductible for Physical, Speech and Occupational Therapy	Treatment of Applied Behavioral Analysis (ABA) for Autism limited to 25 hours of direct line therapy per week per member through age 18. Physical, Occupational, and Speech Therapy limits are combined with Rehabilitation services limits. ABA services not available outside of Michigan.
	Skilled nursing care	No Charge after deductible	No Charge after deductible	Limited to a maximum of 90 days per member per calendar year
	Durable medical equipment	No Charge after deductible	No Charge after deductible	---none---
	Hospice service	No Charge after deductible	No Charge after deductible	---none---
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Eye exam	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic Care
- Coverage provided outside the United States. See http://provider.bcbs.com
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered
- Non-Emergency care when traveling outside the U.S

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at the number on the back of your BCBSM ID card. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross®and Blue Shield®of Michigan by calling the number on the back of your BCBSM ID card. Or, you can contact Michigan Office of Financial and Insurance Regulation at **www.michigan.gov/ofir** or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This health coverage does meet the minimum value standard for the benefits it provides. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier. In these situations you will need to contact your plan administrator for information on whether your plan meets the minimum value standard for the benefits it provides.)

Language Access Services

For assistance in a language below please call the number on the back of your BCBSM ID card.

SPANISH (Español): Para ayuda en español, llame al número de servicio al cliente que se encuentra en este aviso ó en el reverso de su tarjeta de identificación.

TAGALOG (Tagalog): Para sa tulong sa wikang Tagalog, mangyaring tumawag sa numero ng serbisyo sa mamimili na nakalagay sa likod ng iyong pagkakakilanlan kard o sa paunawang ito.

CHINESE (中文): 要获取中文帮助，请致电您的身份识别卡背面或本通知提供的客户服务 号码。

NAVAJO (Dine): Taa'dineji'keego shii'kaa'ahdool'wool ninizin'goo, beesh behane'e naal'tsoos bikii sin'dahiigii binii'deehgo eeh'doodago di'naaltsoo bikaiigii bichi'hoodillnii.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Please note: Coverage examples are calculated based on individual coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,370
- **Patient pays** $2,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$150
Total	**$2,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,920
- **Patient pays** $2,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Co-pays	$400
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,480**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call the number on the back of your BCBSM ID card or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number on the back of your BCBSM ID card to request a copy.

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 3156-0001, 0003
Michigan State University College of Law

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – June 1 through May 31

Covered Services –

	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	80%	80%	80%
Emergency Palliative Treatment – to temporarily relieve pain	80%	80%	80%
Brush Biopsy – to detect oral cancer	80%	80%	80%
Basic Services			
Radiographs – X-rays	50%	50%	50%
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to bridges, dentures, and implants	50%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.

- Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once 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.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per person total per Benefit Year on all services.

Deductible – $25 Deductible per person total per Benefit Year limited to a maximum Deductible of $75 per family per Benefit Year.

Waiting Period – Employees who are eligible for dental benefits are covered on the date of hire.

Eligible People – All full-time faculty and staff employees (0001) and retirees (0003) who elect the Premier dental plan and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable. The Contractor pays the full cost of this plan for Subscribers.

Also eligible are your legal spouse and your children to the end of the calendar year in which they turn 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled and your domestic partner as defined by the contractor. Employees and their dependents choosing a dental plan are required to remain enrolled for a period of 12 months. Should an employee or dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the date on which 24 months have elapsed. Dependents may enroll only if the employee is enrolled (excluding COBRA) and must be enrolled in the same plan as the employee. An election may be revoked or changed at any time if such change is the result of a qualifying event as defined under Internal Revenue Code Section 125. If you and your spouse or domestic partner are both eligible under this Contract, you may be enrolled together on one application card or separately on individual application cards, but not both. Your dependent children may be enrolled on both application cards as well. Delta Dental will coordinate benefits. The Contractor pays the cost of this plan for Subscribers only.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

Effective June 1, 2013-changing Eligible People and Covered Services.

DELTA DENTAL®

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 3156-1001, 1003
Michigan State University College of Law

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – June 1 through May 31

Covered Services –

	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	80%	80%
Emergency Palliative Treatment – to temporarily relieve pain	100%	80%	80%
Brush Biopsy – to detect oral cancer	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	50%	50%
Endodontic Services – root canals	80%	50%	50%
Periodontic Services – to treat gum disease	80%	50%	50%
Oral Surgery Services – extractions and dental surgery	80%	50%	50%
Other Basic Services – misc. services	80%	50%	50%
Relines and Repairs – to bridges, dentures, and implants	80%	50%	50%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Up to age 19	Up to age 19	Up to age 19

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.
- Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once 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.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per person total per Benefit Year on all services except orthodontics. $1,000 per person total per lifetime on orthodontic services.

Deductible – $25 Deductible per person total per Benefit Year limited to a maximum Deductible of $75 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays and orthodontic services.

Waiting Period – Employees who are eligible for dental benefits are covered on the date of hire.

Eligible People – All full-time faculty and staff employees (1001) and retirees (1003) who elect the PPO dental plan and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable. The Contractor pays the full cost of this plan for Subscribers. The Subscriber pays the additional cost of dependent coverage.

Also eligible are your legal spouse and your children to the end of the calendar year in which they turn 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled and your domestic partner as defined by the contractor. Employees and their dependents choosing a dental plan are required to remain enrolled for a period of 12 months. Should an employee or dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the date on which 24 months have elapsed. Dependents may enroll only if the employee is enrolled (excluding COBRA) and must be enrolled in the same plan as the employee. An election may be revoked or changed at any time if such change is the result of a qualifying event as defined under Internal Revenue Code Section 125. If you and your spouse or domestic partner are both eligible under this Contract, you may be enrolled together on one application card or separately on individual application cards, but not both. Your dependent children may be enrolled on both application cards as well. Delta Dental will coordinate benefits.

The Contractor pays the cost of this plan for Subscribers only. The Subscriber pays the additional cost of dependent coverage.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

Effective June 1, 2013-changing Eligible People.

MICHIGAN STATE UNIVERSITY
COLLEGE OF LAW
All Staff Members

All coverages are issued by the Prudential Insurance Company of America.

Basic Term Life, Basic Accidental Death & Dismemberment, Optional Term Life, Optional Dependent Life, Short Term Disability and Long Term Disability

Effective: 04/01/2011

Coverage Options	
Basic Term Life - 100% Employer Paid	• Basic Term Life: You are automatically enrolled for 1 times your covered annual earnings to $400,000. • Basic Dependent Life: Your spouse is automatically enrolled for $2,000. • Basic Dependent Life: Your child(ren) will be automatically enrolled for $1,000. There are no health requirements for this coverage. • Coverage begins from 14 days and continues to age 19, if unmarried. If unmarried, dependent on you and a full time student, coverage continues until age 23. • The death benefit for babies from 14 days to 6 months old is $100. • Evidence of insurability satisfactory to the Prudential Insurance Company of America will be required for amounts over $200,000 to become effective. • If you are terminally ill, you can get a partial payment of your group life insurance benefit. You can use this payment as you see fit. The payment to your beneficiary will be reduced by the amount you receive with the Accelerated Benefit Option. Refer to the plan booklet for details. • Payment of premium can be waived if you are totally disabled for 9 months, you are less than 60 years old when the disability begins, and you continue to be totally disabled. This provision may vary by state. • The amount of insurance reduces by 50% at age 70. • Coverage will end on your termination of employment or as specified in the plan booklet. You may convert your insurance to an individual life insurance policy insured by The Prudential Insurance Company of America.
Basic Accidental Death & Dismemberment - 100% Employer Paid	• Basic AD&D pays you and your beneficiary a benefit for the loss of life or other injuries resulting from a covered accident -- 100% for loss of life and a lesser percentage for other injuries. Injuries covered may include loss of sight or speech, paralysis, and dismemberment of hands or feet. Basic AD&D benefits are paid regardless of other coverages you may have. • Basic AD&D: You are automatically enrolled for an amount equal to your Basic Term Life coverage amount.

Prudential

Optional Term Life - 100% Employee Paid	• **Option 1**: Purchase coverage for $25,000 • **Option 2**: Purchase coverage for $100,000. • **Option 3**: Purchase coverage for $200,000. • **New Hires:** Get up to $200,000 - no medical questions asked - when enrolling when first eligible. • **Current Participants:** Your current coverage amount will be continued. Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all increases in coverage amounts. • **Current Employees who were denied coverage in the past or Late Entrants:** Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all coverage amounts. • If you are terminally ill, you can get a partial payment of your group life insurance benefit. You can use this payment as you see fit. The payment to your beneficiary will be reduced by the amount you receive with the Accelerated Benefit Option . Refer to the plan booklet for details.
Spouse - Optional Dependent Life - 100% Employee Paid	• Purchase $15,000 coverage for your spouse not to exceed 50% of Basic life coverage amount. • **New Hires:** Get $15,000 - no medical questions asked - when enrolling when first eligible. • **Current Spouse Participants:** Your spouse's current coverage amount will be continued. Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all increases in coverage amounts. • **Current Employees whose spouse has been denied coverage in the past or Late Entrants:** Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all coverage amounts.
Child Optional Dependent Life - 100% Employee Paid	• Purchase coverage for $10,000. There are no health requirements for this coverage. • Coverage begins from 14 days, and continues to age 19, if unmarried. If unmarried, dependent on you and a full-time student, coverage continues to age 25. • The death benefit for babies from 14 days to 6 months old is $500.
Short Term Disability - 100% Employer Paid	• Your weekly Short Term Disability benefits will be 66 2/3% of your weekly pre-disability earnings, up to a maximum of $200, less deductible sources of income. Deductible sources of income may include benefits from statutory plans, unemployment income, and salary continuation. • The minimum weekly benefit is $25. • If you meet the definition of disability, your benefits will begin on the 30th day following a non-occupational injury or the 30th day following a non-occupational sickness. The benefit duration is 22 weeks. During the elimination period, you are considered disabled when, because of injury or sickness, you are under the regular care of the doctor, are unable to perform the material and substantial duties of your regular occupation and you are not working at any job. After the elimination period, you are considered disabled when, because of injury or sickness, you are under the regular care of the doctor, are unable to perform the material and substantial duties of your regular occupation and your disability results in a loss of weekly income of at least 20%. • You are not covered for a disability caused by war or any act of war, declared or undeclared, an intentionally self-inflicted injury, active participation in a riot, and commission of a crime for which you have been convicted. Benefits are not payable for any period of incarceration as a result of a conviction.

Long Term Disability	• **Option 1:** 100% Employer Paid **–** Your monthly Long Term Disability benefit will be 60% of your monthly pre-disability earnings, up to the maximum of $15,000, less deductible sources of income. • **Option 2:** 100% Employee Paid - Your monthly Long Term Disability benefit will be 70% of your monthly pre-disability earnings, up to the maximum of $15,000, less deductible sources of income. No medical questions asked - if enrolling when first eligible. Deductible sources of income may include benefits from statutory plans, Social Security to you and your dependents, worker's compensation, unemployment income and other income. • The minimum monthly benefit is the lesser of 15% of your gross monthly benefit or $100. • If you meet the definition of disability, your benefits will begin 180 days following an accidental injury or sickness. The benefit duration is up to your normal retirement age under the Social Security Act. However, if you become disabled at or after age 65 benefits are payable according to an age-based schedule. Refer to the Booklet-Certificate for details. • During the elimination period, you are considered disabled when, because of injury or sickness, you are unable to perform the material and substantial duties of your regular occupation, you are under the regular care of a doctor and you are not working at any job. After the elimination period, you are considered disabled when, because of injury or sickness, you are unable to perform the material and substantial duties of your regular occupation, you are under the regular care of a doctor and your disability results in a loss of income of at leat 20%. • Disabilities due to mental illness are limited to 24 months of benefits during your lifetime. Examples of mental illness include schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, substance related disorders (including drug and alcohol abuse), and/or adjustment disorders. Disabilities due to mental illness have a combined limited pay period during your lifetime. • LTD benefits will not be paid for a disability that begins during the first 12 months of coverage and due to a pre-existing condition. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, diagnostic measures, prescribed drugs or medicines, or for which you followed treatment recommendations during the 3 months prior to your effective date of coverage. • If you die while collecting disability benefits, a lump sum payment may be paid to your eligible survivors. • You are not covered for a disability caused by war or any act of war, declared or undeclared, an intentionally self-inflicted injury, active participation in a riot, and commission of a crime for which you have been convicted. Benefits are not payable for any period of incarceration as a result of a conviction.

Benefits, exclusions and provisions may vary by state. Refer to the plan booklet for details.

For your coverage to become effective, you must be actively at work on the effective date of the plan. If you apply for an amount that requires satisfactory evidence of insurability to the Prudential Insurance Company of America, you must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.

Group Term Life, Accidental Death and Dismemberment and Disability coverages are issued by The Prudential Insurance Company of America, **a New Jersey Company**, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542 and Disability Support: 1-800-842-1718. Prudential Financial and the Rock logo are registered service marks of The Prudential Insurance Company of America and its affiliates. This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract Series: 83500. California COA #1179 NAIC # 68241

MICHIGAN STATE UNIVERSITY
COLLEGE OF LAW
All Faculty Employees

All coverages are issued by the Prudential Insurance Company of America.

Basic Term Life, Basic Accidental Death & Dismemberment, Optional Term Life, Optional Dependent Life and Long Term Disability

Effective: 04/01/2011

Coverage Options	
Basic Term Life - 100% Employer Paid	• Basic Term Life: You are automatically enrolled for 1 times your covered annual earnings to $400,000. • Basic Dependent Life: Your spouse is automatically enrolled for $2,000. • Basic Dependent Life: Your child(ren) will be automatically enrolled for $1,000. There are no health requirements for this coverage. • Coverage begins from 14 days and continues to age 19, if unmarried. If unmarried, dependent on you and a full time student, coverage continues until age 23. • The death benefit for babies from 14 days to 6 months old is $100. • Evidence of insurability satisfactory to the Prudential Insurance Company of America will be required for amounts over $200,000 to become effective. • If you are terminally ill, you can get a partial payment of your group life insurance benefit. You can use this payment as you see fit. The payment to your beneficiary will be reduced by the amount you receive with the Accelerated Benefit Option. Refer to the plan booklet for details. • Payment of premium can be waived if you are totally disabled for 9 months, you are less than 60 years old when the disability begins, and you continue to be totally disabled. This provision may vary by state. • The amount of insurance reduces by 50% at age 70. • Coverage will end on your termination of employment or as specified in the plan booklet. You may convert your insurance to an individual life insurance policy insured by The Prudential Insurance Company of America.
Basic Accidental Death & Dismemberment - 100% Employer Paid	• Basic AD&D pays you and your beneficiary a benefit for the loss of life or other injuries resulting from a covered accident -- 100% for loss of life and a lesser percentage for other injuries. Injuries covered may include loss of sight or speech, paralysis, and dismemberment of hands or feet. Basic AD&D benefits are paid regardless of other coverages you may have. • Basic AD&D: You are automatically enrolled for an amount equal to your Basic Term Life coverage amount.

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Optional Term Life - 100% Employee Paid	• **Option 1**: Purchase coverage for $25,000 • **Option 2**: Purchase coverage for $100,000. • **Option 3**: Purchase coverage for $200,000. • **New Hires:** Get up to $200,000 - no medical questions asked - when enrolling when first eligible. • **Current Participants:** Your current coverage amount will be continued. Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all increases in coverage amounts. • **Current Employees who were denied coverage in the past or Late Entrants:** Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all coverage amounts. • If you are terminally ill, you can get a partial payment of your group life insurance benefit. You can use this payment as you see fit. The payment to your beneficiary will be reduced by the amount you receive with the Accelerated Benefit Option . Refer to the plan booklet for details.
Spouse - Optional Dependent Life - 100% Employee Paid	• Purchase $15,000 coverage for your spouse not to exceed 50% of Basic life coverage amount. • **New Hires:** Get $15,000 - no medical questions asked - when enrolling when first eligible. • **Current Spouse Participants:** Your spouse's current coverage amount will be continued. Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all increases in coverage amounts. • **Current Employees whose spouse has been denied coverage in the past or Late Entrants:** Evidence of insurability satisfactory to The Prudential Insurance Company of America is required for all coverage amounts.
Child Optional Dependent Life - 100% Employee Paid	• Purchase coverage for $10,000. There are no health requirements for this coverage. • Coverage begins from 14 days, and continues to age 19, if unmarried. If unmarried, dependent on you and a full-time student, coverage continues to age 25. • The death benefit for babies from 14 days to 6 months old is $500.

Long Term Disability	• **Option 1:** 100% Employer Paid **–** Your monthly Long Term Disability benefit will be 60% of your monthly pre-disability earnings, up to the maximum of $15,000, less deductible sources of income. • **Option 2:** 100% Employee Paid - Your monthly Long Term Disability benefit will be 70% of your monthly pre-disability earnings, up to the maximum of $15,000, less deductible sources of income. No medical questions asked - if enrolling when first eligible. Deductible sources of income may include benefits from statutory plans, Social Security to you and your dependents, worker's compensation, unemployment income and other income. • The minimum monthly benefit is the lesser of 15% of your gross monthly benefit or $100. • If you meet the definition of disability, your benefits will begin 180 days following an accidental injury or sickness. The benefit duration is up to your normal retirement age under the Social Security Act. However, if you become disabled at or after age 65 benefits are payable according to an age-based schedule. Refer to the Booklet-Certificate for details. • During the elimination period, you are considered disabled when, because of injury or sickness, you are unable to perform the material and substantial duties of your regular occupation, you are under the regular care of a doctor and you are not working at any job. After the elimination period, you are considered disabled when, because of injury or sickness, you are unable to perform the material and substantial duties of your regular occupation, you are under the regular care of a doctor and your disability results in a loss of income of at leat 20%. • Disabilities due to mental illness are limited to 24 months of benefits during your lifetime. Examples of mental illness include schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, substance related disorders (including drug and alcohol abuse), and/or adjustment disorders. Disabilities due to mental illness have a combined limited pay period during your lifetime. • LTD benefits will not be paid for a disability that begins during the first 12 months of coverage and due to a pre-existing condition. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, diagnostic measures, prescribed drugs or medicines, or for which you followed treatment recommendations during the 3 months prior to your effective date of coverage. • If you die while collecting disability benefits, a lump sum payment may be paid to your eligible survivors. • You are not covered for a disability caused by war or any act of war, declared or undeclared, an intentionally self-inflicted injury, active participation in a riot, and commission of a crime for which you have been convicted. Benefits are not payable for any period of incarceration as a result of a conviction.

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Hylant Script Navigator

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2 dosage

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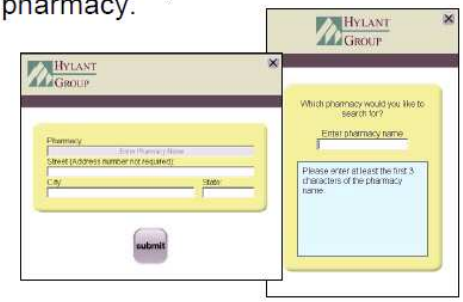

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