NORTH AMERICAN DIVISION BENEFITS
Healthcare

NORTH AMERICAN DIVISION

Healthcare Assistance Plan

2017 PLAN YEAR

SUMMARY PLAN INFORMATION

COMPARISON OF PLAN BENEFITS

North American Division Health Care Assistance Plan Members

With your North American Division Health Care Assistance Plan (NAD HCAP) benefit ID card, you have access to two Preferred Provider Organizations for your health care needs. They are the Aetna Signature Administrators Preferred Provider Organization (PPO) for both medical and dental care; and Express Scripts for prescription benefits. In addition, you have access to vision care services with no PPO requirement.

Enrollment Guidelines

Eligible Family Members

Family members who may also take advantage of the health plan benefits through the NAD HCAP include:

- Your non-working spouse. If your spouse is employed, additional eligibility rules established by your employer may exist. Verify these details with your Human Resources office.
- Children up to age 26 (regardless of their student status, marital status, employment status, or if they are claimed as a dependent for income tax purposes)
- Children of any age if your unmarried adult child was disabled before age 26, and the disabled status is current and ongoing.

When Coverage Begins

If you are electing benefits during Annual Open Enrollment, your benefit elections will become effective January 1, 2017. If you are a new employee or newly benefit-eligible, your benefits will be effective at the end of your waiting period or elimination period. If your employer does not have a waiting period, you may be benefit-eligible effective on your date of hire. You will need to confirm these details with your Human Resources office.

Payroll deductions for Plan participation and coverage tiers are determined by your employer.

Coverage Tier

Based on family status and qualifying dependents you may choose from one of the following coverage tiers:

- **Employee Only** – you only with no other covered family members
- **Employee + Spouse** – you and your spouse
- **Employee + Child/ren** – you and your child or children
- **Family** – You, a spouse and at least one child

Making Benefit Elections

Annual Open Enrollment gives you opportunity to make changes to your benefit elections for your health plan coverage which includes medical, dental, vision, and prescription benefits. After your enrollment deadline has passed, you can change your coverage tier (Employee Only, Employee + Spouse, Employee + Children, Family) during the year only if you experience an IRS-qualifying life status change, such as marriage, divorce, birth, adoption, death of a spouse or child, change in employment status or changes in availability of other coverage (such as losing coverage under a spouse's plan). Within 30 days of any one of these instances you may add or delete a family member from your benefit coverage. For instance, having a baby will allow you to add your newborn to your health plan, and as such may change your family tier from "Employee + Spouse" to "Family".

Without a documented qualifying disability status, your child will be terminated on his/her 26th birthday with no election change required by you even though this could potentially change your coverage tier from "Family" to "Employee + Child" or "Employee + Spouse" for example.

For new employees, your enrollment period is the 30-day period after your date-of-hire. Your benefit election option will be the "Legacy Plan" or the "Standard Plan". Benefit categories cannot be mixed between these two Plan options. In other words, you cannot enroll in the "Legacy" medical plan, but the "Standard" dental plan.

Added Family Member Verification

If you enroll a new family member in your health plan benefits, you may be required to provide documentation to your employer for confirmation of the individual's eligibility. If you do not provide requested documentation such as marriage license, birth certificate, loss of other coverage verification, etc., your family member may lose coverage.

If your spouse or dependent child also works for an employer covered by the North American Division Health Care Assistance Plan (NAD HCAP), and they qualify for health plan benefits as an employee, they must generally enroll in the health care plan through their own employer. Your spouse and/or child cannot be covered as both an employee and as a dependent. If your employer permits secondary coverage and your child is covered under both your plan and your spouse's plan (non-NAD HCAP plan), the birthday rule will determine which plan is primary and which plan is secondary. This rule is only engaged if the child is covered under both plans. The parent whose birthday is first in the year (month and day) will be primary.

Health Plan Provider Networks and Benefits

You will have a single member benefit ID card that will serve as access to medical, dental, vision and prescription services as well as Member Services. The following networks and benefits are available to you through this health plan.

Aetna Signature Administrators - Medical and Dental Provider Network

With your health plan member ID card, you have access to doctors and hospitals almost anywhere. The Aetna network gives you the peace of mind that you will always have the care you need whether at home or when traveling. As long as you access a provider participating in the Aetna PPO network, your services will be processed as "in-network" and apply to your "in-network" deductible and out-of-pocket maximum responsibility. You will be responsible for copays at the time of service; typically you will pay your deductible and/or coinsurance portion after the Plan has paid its portion.

Express Scripts – Prescription Benefit Manager

You have both a retail and mail-order benefit available with their respective copay responsibilities and expectations. There is also an established maximum out-of-pocket responsibility. Each copayment you make accrues toward this out-of-pocket responsibility.

Plan Benefits Not Requiring Network Participation

Vision services do not require the use of network providers. You will receive your vision services, pay, and submit receipts for reimbursement. With complete documentation, the reimbursement process is less than two weeks.

Member Services

HealthSCOPE Benefits is the Plan's chosen third party administrator for claims adjudication and member services for all plan benefits except prescription. Express Scripts continues to be the Plan's prescription benefit manager and customer service.

Emergency Care

In case of an emergency, go directly to the nearest hospital.

If your emergency room visit results in admission, the hospital should call the pre-certification phone line and register the admission and complete the pre-certification documentation requirements. If the admission is in an out-of-network facility, the pre-certification staff will determine if you should be transferred to an in-network facility or continue your treatment in the admitting facility.

Routine or Non-Emergent Care

- Always carry your member ID card for easy reference and access to service.
- To find names and addresses of nearby doctors and hospitals, visit the Aetna Signature Administrator's on-line Provider Directory at *https://www.aetna.com/asa*. During business hours, your Member Services office can be reached at **1-888-276-4SDA.**
- To ensure best use of your health plan benefits, ensure you access care within the Aetna Signature Administrator Preferred Provider network.

- While pre-certification requirements are usually completed by the provider, to eliminate potential financial penalty for non-pre-certification, it is member responsibility to ensure this has been done. The pre-certification phone number is on the back of your benefit card.
- When you arrive at the doctor's office or hospital, present your member ID card.

- After you receive care, you should not have to complete claim forms or have to pay up front for medical services other than the usual out-of-pocket expense. HealthSCOPE Benefits will send you a monthly statement of all services processed and paid to-date. For any services denied, you will receive a separate Explanation of Benefits (EOB). These same services will also be included on your monthly summary statement.

International Coverage

Your health care plan provides for emergency services outside the United States. You should always carry your member ID card when you travel outside the United States. Follow the same process as if you were in the U.S., and as needed, call your Member Services phone number **(888) 276-4732**. HealthSCOPE Benefits will coordinate care and billing concerns for needed emergency services while out of the country including medical assistance services, locating a doctor, hospital and other health care professionals around the world.

Remember, international benefit coverage is only for emergency services while out of the country. The health Plan does not cover repatriation or transportation back to the United States. When traveling abroad, you may want to consider purchasing short-term-travel insurance which covers repatriation among other things such as lost personal effects and baggage, trip cancellation and interruption benefits.

Health Plan Online Services

At *http://www.adventistrisk.org/employee-benefits/healthcare-benefits/heathcare-plan-info* members of the NAD HCAP have access to their health plan benefit information as well as other health related information.

- Review your explanation of benefits
- Find information about covered healthcare services
- Request a new or replacement member ID card
- Search for providers
- Register and report points to the plan's wellness incentive program.

For access to your prescription benefits, to review medication options or to enroll in the mail-order program, access Express Scripts at *http://www.express-scripts.com/*.

MAJOR MEDICAL BENEFITS	MEMBER RESPONSIBILITY			
	LEGACY PLAN		STANDARD PLAN	
Medical	In-Ntwk	Out-of-Ntwk	In-Ntwk	Out-of-Ntwk
Preventive Services • Age, gender and frequency criteria • Adult physical/immunizations • Well child visits/immunizations • Screenings	0	40%	0	50%
Co-Insurance (after deductible) **Out-of-Pocket Maximums** Individual Family	20% $2,500 $5,000	40% $4,750 $9,500	20% $5,000 $10,000	50% $10,000 $20,000
Office Visit (copays) • Applies to office visit charge only • Does not apply to Plan Year deductible • Copay does not apply to out-of-pocket maximum • All other services apply to deductible and coinsurance	$25	$40	$50	$80
Plan Year Deductible Individual Family	$300 $600	$400 $800	$600 $1,200	$2,500 $5,000
Outpatient Services • Apply to Plan Year deductible and coinsurance • Pre-certification may be required	20%	40%	20%	50%
Diagnostic Services Advanced imaging (e.g., PET, MRI, CT) Other imaging (e.g., x-ray, sonogram Lab and other services	20%	40%	20%	50%
Office / Ambulatory Surgical Procedures • Pre-certification required to receive full Plan benefits • Applies to Plan Year deductible and coinsurance	20%	40%	20%	50%
Urgent Care Centers • May be paid as an office visit or as an emergency room visit according to provider contract • Facility fees for office visits are not paid	$25 or $100 + 20%	$40 or $100 + 40%	$50 or $200 +20%	$80 or $200 +50%
Emergency Room May have both a copay and coinsurance component • Copay for base ER visit • Other charges apply to deductible and coinsurance • Copayment waived if admitted	$100 + 20%	$100 + 20%	$200 + 20%	$200 + 20%

MAJOR MEDICAL BENEFITS	MEMBER RESPONSIBILITY			
	LEGACY PLAN		STANDARD PLAN	
Medical	In-Ntwk	Out-of-Ntwk	In-Ntwk	Out-of-Ntwk
Hospitalization In-Patient • Applies to Plan Year deductible and coinsurance • Requires pre-certification	20%	40%	20%	50%
Skilled Nursing Facility Medical Rehabilitation Coverage • Requires pre-certification • 120 day Plan Year limit • Applies to Plan Year deductible and coinsurance	20%	40%	20%	50%
Durable Medical Equipment • $8,000 maximum payment per Plan Year • Purchases may require pre-certification • All rentals require pre-certification • Applies to Plan Year deductible and coinsurance	20%	40%	20%	50%
Mental Health Outpatient Services / Partial Hospitalization	$25	$40	$50	$80
May have both an office visit and a coinsurance component • All other charges apply to deductible and coinsurance • Services may require pre-certification	20%	40%	20%	50%
Mental Health Inpatient Services • Pre-certification required to receive full Plan benefits • Applies to Plan Year deductible and coinsurance	20%	40%	20%	50%
Substance Abuse/Chemical Dependency Outpatient/Partial Facility Visits May have both an office visit and a coinsurance component • All other charges apply to deductible and coinsurance • Services may require pre-certification	$25 20%	$40 40%	$50 20%	$80 50%
Substance Abuse/Chemical Dependency Inpatient Treatment • Pre-certification required to receive full Plan benefits • Applies to Plan Year deductible and coinsurance	20%	40%	20%	50%
Hearing Care Professional Testing/Screening • Applies to Plan Year deductible and coinsurance	20%	40%	20%	50%
Home Health Care • Maximum of 120 visits per Plan Year • Pre-certification required to receive full Plan benefits • Applies to Plan Year deductible and coinsurance	20%	40%	20%	50%

MAJOR MEDICAL BENEFITS	MEMBER RESPONSIBILITY			
	LEGACY PLAN		STANDARD PLAN	
Medical	In-Ntwk	Out-of-Ntwk	In-Ntwk	Out-of-Ntwk
Hospice Care • Paid at 100% of allowable charges • Pre-certification required to receive full Plan benefits	0	0	0	0
Infertility Treatment • Lifetime maximum benefit $16,000 • Does not apply to Plan Year deductible or coinsurance	25%	25%	50%	50%
Organ/Tissue Transplants • Pre-certification required • Applies to Plan Year deductible and coinsurance	20%	40%	20%	50%
Vision Therapy • Lifetime maximum of 8 visits • Pre-certification required • Applies to Plan Year deductible and coinsurance	20%	40%	20%	50%
Therapeutic Services Physical Therapy, Occupational Therapy, Speech Therapy • Bundled benefit with a collective limit of 90; no single therapeutic category to exceed 60 visits per Plan year • Applies to Plan Year deductible and coinsurance • Pre-certification required	20%	40%	20%	50%

While categorized as medical benefits, the following services do not require PPO Network utilization

Hearing Aids • Plan Year maximum payable benefit of $3,200 • Does not apply to Plan Year deductible • Does not apply to coinsurance	20%		20%	
Refractive Eye Surgery • Lifetime maximum payable benefit of $2,400	20%		50%	
Alternative Therapies Bundled benefit with a collective limit of 45 alternative therapy visits per Plan Year; no single therapy category to exceed 30 visits per Plan Year.				
Chiropractic Services • Visit limits apply • Limited to spinal manipulation • One annual office visit and x-ray • Must be age 11 or older	20%		50%	
Acupuncture Therapy • Visit limits apply • Must be age 18 or older	50%		Not Covered	
Massage Therapy • Visit limits apply • Must be age 18 or older	50%		Not Covered	

	MEMBER RESPONSIBILITY			
	LEGACY PLAN		STANDARD PLAN	
DENTAL	In-Ntwk	Out-of-Ntwk	In-Ntwk	Out-of-Ntwk
Plan Year Deductible Individual Family	 $100 $300	 $150 $450	 $250 $750	 $500 $1,500
Co-Insurance (after deductible)	20%	25%	20%	50%
Maximum Payable Benefit Per Plan Year Individual Family	 $2,500 $7,500		 $1,250 $3,750	
Dental Care Preventive Care • Paid at 100% • Does not apply to Plan Year Deductible • Does apply to Plan Year maximum payable benefit Restorative Care • Applies to Dental Plan Year deductible • Usual, Reasonable and Customary (U&C) applies • Pre-determination may be required	 $0 20%	 $0 25%	 $0 20%	 $0 50%
Orthodontic Care • Paid at 50% of allowable charges • $2,300 maximum lifetime payable • Eligible up to age 24 (through age 23)	50%		50%	

	MEMBER RESPONSIBILITY			
	LEGACY PLAN		STANDARD PLAN	
VISION	In-Ntwk	Out-of-Ntwk	In-Ntwk	Out-of-Ntwk
Vision Care **Plan Paid Maximum** **Member Responsibility** • All charges in excess of Plan Year benefit limit • Does not apply to Plan Year deductible • Does not apply to Plan Year coinsurance	 $450 20%		 $225 20%	

	MEMBER RESPONSIBILITY	
	LEGACY PLAN	STANDARD PLAN
PRESCRIPTION		
Out-of-Pocket Maximums		
Individual	$750	$2,500
Family	$1,500	$5,000

NOTE: At retail, your employer may utilize a percentage of cost or a copayment as member responsibility. Mail order is always a copayment.

Clients with flat-dollar copayments at both retail and mail		
Retail – 30-day supply		
Generic	$10	$10
Brand (Preferred)	$20	$50
Non-Formulary (Non-Preferred)	$40	$100
Mail Order – 90-day Supply		
Generic	$20	$20
Brand (Preferred)	$40	$100
Non-Formulary (Non-Preferred)	$80	$200
Clients with percentage of cost at retail and flat dollar copay at mail		
Retail – 30-day supply		
Generic	20%	20%
Brand (Preferred)	20%	20%
Non-Formulary (Non-Preferred)	20%	20%
Mail Order – 90-day Supply		
Generic	$20	
Brand (Preferred)	$40	$20
Non-Formulary (Non-Preferred)	$80	$100
		$200

- Copayments apply to the prescription benefit out-of-pocket maximums.
- Penalties for non-compliance do not apply toward Plan Year out-of-pocket maximums.
- Preventive Care prescriptions paid by Plan at 100% (and Members pay $0)

IMPORTANT NOTICE CONCERNING NON-PARTICIPATING BENEFITS

If you reside in a PPO area, but you elect not to participate in the participating provider program, your covered benefits will be reduced in four major ways:

1. Difference in deductible from In-Network benefits to Out-of-Network benefits
2. Difference in out-of-pocket maximum paid from In-Network benefits to Out-of-Network benefits
3. Charges in excess of Usual and Customary
4. Difference in Copay from In-Network benefits to Out-of-Network benefits

NOTE: The Out-of-Network deductible and coinsurance responsibilities are in addition to or separate from the In-Network deductible and coinsurance responsibilities. If you utilize a combination of in-network and out-of-network providers, your member responsibility could be as high as both in-network and out-of-network responsibilities combined.

PREVENTIVE CARE SERVICES - MEDICAL

The Plan pays benefits for Preventive Care Services as required by health care reform. These Preventive Care Services are summarized in this Section. Benefits will be covered under this Preventive Care Services benefit, not any other benefit, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force, the Health Resources and Services Administration, or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit.

If you utilize an in-network Provider for Preventive Care Services, the Plan pays 100% of the cost of these Covered Services, without co-payments, and the Plan deductibles do not apply. Preventive Care Services performed by an out-of-network provider will not qualify at the 100% benefit rate, but may be eligible for consideration at the out-of-network rate of 60% of Usual and Customary.

Preventive Care services are generally performed to prevent disease or to catch the early warning signs of health problems. Preventive Care Services are only covered if you have no symptoms of disease. You are not eligible for these benefits if you are receiving medical services to treat an illness or injury, although you are eligible for benefits for services to treat an illness or injury under other provisions of the Plan. If during a preventive screening examination and/or service, a condition is discovered and treatment is rendered during that visit, the transition from 'preventive' status to 'treatment' status may cause the claim to be processed with applicable deductible and out-of-pocket responsibility.

The appropriateness of Preventive Care covered Services and are reviewed and periodically may change the frequency or type of Preventive Care Services. The Plan will provide notice of any such changes by amendment to the Plan.

This only describes the Preventive Care Services for which benefits are paid by the Plan. The Plan does not provide medical advice and is not to be considered a substitute for the medical judgment of your attending physician or other health care provider. Even though the Plan covers a test or an immunization, your physician may recommend that you do not undertake the test or immunization, and may recommend that you have tests or immunizations not covered by the Plan. In all instances, the final and ultimate decisions concerning the appropriate and desired immunizations, tests, and other preventive care measures and medical treatments are up to you and the physician or other professional providing your treatment.

1. Pediatric Preventive Care Covered Services

The Plan pays benefits for the following Pediatric Preventive Care Covered Services:

A. Physical Examination, Routine History, Routine Diagnostic Tests. Benefits for well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, are limited to Members who are less than eighteen (18) years of age in accordance with the schedule shown below. When a range is given (i.e. 2-3 months), the dash indicates that benefits are provided for one service from two (2) months through three (3) months of age.

Twenty-four (24) examinations up to age seventeen (17) – according to each of the following age groupings:

- Eight (8) exams between the ages of 0-24 months, consisting of one (1) exam within each of the following age ranges:

00-01 months	09-11 months
02-03 months	12-14 months
04-05 months	15-17 months
06-08 months	18-24 months

- One (1) exam every calendar year between three (3) and seventeen (17) years of age

B. Blood Lead Screening. This blood test detects elevated lead levels in the blood.
Children participating in the Plan are covered for:
- One (1) test between 9-12 months of age
- One (1) test at twenty-four (24) months of age

C. Hemoglobin/Hematocrit. This blood test measures the size, shape, number and content of red blood cells.
Children participating in the Plan are covered for:
- One (1) test between 0-12 months of age
- One (1) test between one (1) and four (4) years of age
- One (1) test between five (5) and twelve (12) years of age
- One (1) test between thirteen (13) and seventeen (17) years of age

D. Rubella Titer Test. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, your physician may recommend that a rubella immunization should be given. The rubella titer blood test may be recommended by your physician if there is uncertainty whether the child has ever been immunized. Children participating in the Plan are covered for one (1) test and immunization between eleven (11) and seventeen (17) years of age.

E. Urinalysis. This test detects numerous abnormalities. Children are covered for:
- One (1) test every 365 days between 0-24 months of age
- One (1) test every calendar year between two (2) and seventeen (17) years of age

2. Pediatric Immunizations Preventive Care Covered Services

Benefits will be provided for those pediatric immunizations, including the immunizing agents, which conform to the Standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services (HHS). Benefits are limited to Covered Persons under twenty-one (21) years of age.

3. Adult Preventive Care Covered Services (18 Years or Older)

A. Physical Examination, Routine History. The Plan provides benefits for well-person physical examination and counseling for Members eighteen (18) years of age or older in accordance with the following schedule:
- One (1) examination every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
- One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
- One (1) examination every calendar year, beginning at forty (40) years of age

B. Adult Immunization. Benefits will be provided for those adult immunizations, including the immunizing agents, which conform to the Standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, US Department Health and Human Services (HHS). Benefits are limited to covered persons age 18 and over. Please contact Member Services to determine if a particular immunization is covered.

C. Blood Cholesterol Test. High blood cholesterol is one of the risk factors for coronary artery disease. The Plan provides benefits for a blood test measuring the total serum cholesterol level in accordance with the following schedule
- One (1) test every four (4) calendar years between eighteen (18) and thirty-nine (39) years of age
- One (1) test every calendar year, beginning at forty (40) years of age

D. Complete Blood Count (CBC). The Plan provides benefits for this blood test which checks the red and white blood cell levels, hemoglobin and hematocrit as follows:
- One (1) test every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one years of age
- One (1) test every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
- One (1) test every calendar year, beginning at forty (40) years of age

E. Fecal Occult Blood Test. The Plan provides benefits for this test checking the presence of blood in the feces, which is an early indicator of colorectal cancer as follows:
- One (1) test every calendar year beginning at fifty (50) years of age

F. Flexible Sigmoidoscopy. The Plan provides benefits for this test, which is conducted to detect possible colorectal cancer by use of a flexible fiber optic sigmoidscope, as follows:
- One (1) test every three (3) calendar years, beginning at fifty (50) years of age

G. Prostate Specific Antigen (PSA). The Plan provides benefits for this blood test which may be used to detect tumors of the prostate, as follows:
- One (1) test every calendar year for men, beginning at fifty (50) years of age

H. Routine Colonoscopy. The Plan provides benefits for this test used to detect colorectal cancer by use of a flexible fiber optic colonoscope, as follows:
- One (1) test every ten (10) calendar years, beginning at fifty (50) years of age

I. Thyroid Function Test. The Plan pays benefits for this test to detect hyperthyroidism and hypothyroidism, as follows:
- One (1) series of test every calendar year, beginning at eighteen (18) years of age

J. Urinalysis. The Plan pays benefits for this test to detect numerous abnormalities, as follows:
- One (1) test every calendar year, beginning at eighteen (18) years of age

K. Fasting Blood Glucose Test. The Plan pays benefits for this test used for detection for diabetes, as follows:
- One (1) test every three (3) years beginning at forty-five (45) years if age

L. Abdominal Aortic Aneurysm screening. The Plan pays benefits for one (1) screening per lifetime for men only (this screening is not

recommended by HHS for women). Your physician may recommend this screening for men with a smoking history.

- One (1) ultrasound between sixty-five (65) and seventy-five (75) years of age

M. HIV Tests. The Plan pays benefits for test to determine if the patient has HIV.

4. Routine Gynecological Examination, Pap Smear, Sterilization, HPV DNA Testing

Benefits are provided for women covered by the Plan who are eighteen years of age or older for one (1) routine gynecological examination each calendar year, including a pelvic examination and clinical breast examination; and routine Pap smears in accordance with the recommendation of the American College of Obstetricians and Gynecologists. Benefits are provided for sterilization procedures for women. For women 30 years or older, benefits are provided for human papillomavirus (HPV) DNA testing.

5. Mammograms

Benefits are provided for women covered by the Plan who are eighteen (18) years of age or older, coverage for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992.

6. Breastfeeding support, supplies and counseling

Benefits are provided for support, supplies and counseling for women who are breastfeeding.

7. Osteoporosis Screening (Bone Mineral Density Testing or BMBT)

Benefits are provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Covered Provider legally authorized under law to prescribe such a test.

One (1) screening test every two calendar years beginning at age 65

8. Additional Immunizations for High Risk Members

If you are considered to be in a "high risk" population, benefits may be provided for certain immunizations not otherwise covered by the Plan.

PREVENTIVE CARE SERVICES – PRESCRIPTION

The Plan pays benefits for Preventive Care Prescriptions as required by health care reform. These Prescriptions are summarized below. The Plan pays 100% of the cost of these Covered Services, without co-payments, and the Plan deductibles do not apply. The following list of preventive medications shall be used as a guide and should not be considered a comprehensive listing of medications available or covered without cost-sharing. Coverage of any of the listed medications (including all over-the-counter medications) requires a prescription from a licensed health care provider and must be filled at a participating network pharmacy. Additional plan requirements may apply (i.e., pre-auth, home delivery).

Drug or Drug Category

1. Aspirin
   Aspirin 81 MG and 325 MG

   a. Men ages 45 to 79 years who are at increased risk of cardiovascular event
   b. Women ages 55 to 79 years who are at increased risk of cardiovascular event
   c. Women of childbearing years who are at increased risk of preeclamplsia

2. Bowel Prep Agents
   Bisacodyl, Magnesium Citrate, Milk of Magnesia, PEG 3350-Electrolyte

   a. Men and women ages >49 and <76 years of age
   b. Fill Limit: 2 prescriptions per 365 days

3. Female Contraception Methods – all FDA-approved methods of contraception for women; hormonal, barrier, emergency, and implanted devices including over-the-counter contraceptive methods, oral contraceptives, and contraceptive devices

   Women up to age 50 years

4. Folic Acid
   Folic acid tablet 0.4 MG and 0.8 MG; prenatal vitamins with folic acid; multivitamins with folic acid

   Women through age 50 years

5. Iron Supplements
   Iron (various strengths) drops, liquid, suspension, granules; chewable 0.25 MG and 0.5 MG; drops 0.25 MG and 0.5MG; suspension

   Children ages 6 to 12 months who are at risk for iron deficiency anemia

6. Oral Fluoride
   Fluoride chewable tablet 0.25 MG and 0.5 MG; Fluoride drops 0.125 MG, 0.25 MG and 0.5 MG

   Children older than 6 months of age through age 5

7. Smoking Cessation
   Bupropion SR 150 MG; Chantix; Nicotine gum, lozenge, and patch (OTC products only)

   Men and women ages > 18 who use tobacco products

8. Vitamin D
   Vitamin D 1,000 units or less per dose u nit; calcium with vitamin D

   Men and women ages >65 who are at risk of falls

9. Breast Cancer Primary Prevention
   Tamoxifen, raloxifene, and Soltamox (Tamoxifen liquid)

   When prescribed for use in primary prevention of invasive breast cancer in women at high risk.