Summary of Changes in Health Coverage

Everence Insurance Company, as agent of the plan, has prepared this summary on behalf of the Mennonite Educators Benefit Plan for Goshen College.

This summary briefly explains the changes made to the plan effective July 1, 2015. For easy reference, the headings correspond to those listed in your summary plan description. This summary is provided for informational purposes only. Please see your summary plan description for complete details and information.

Definitions

The following definitions have been added to the plan:

Employee — Any person who is employed and compensated for services by the MEBP employer in a legal employer-employee relationship, is a common-law employee of the MEBP employer, and is on the MEBP employer’s W-2 payroll. For purposes of this plan, the term “employee” does not include leased employees, independent contractors, or self-employed individuals, whether or not any such persons are on the MEBP employer’s W-2 payroll.

“Full-time” status employee — For the purposes of this plan only, a “full-time” status employee is an employee who is employed an average of at least 30 hours of service per week with the MEBP employer in accordance with the MEBP employer’s Policy for Determining Full-time Employment Status Under Internal Revenue Code Section 4980H which is attached to this summary plan description as Appendix A. This definition applies to this plan only. It does not define employment status for any other employee benefit plan provided by the MEBP employer and does not refer to employment status for any other employment purposes.

Grandfathered employee — Staff and administrative faculty of the MEBP employer who:
1. Were covered under this plan on June 30, 2014;
2. Have been continuously covered under this plan since June 30, 2014; and
3. Have been working at least 20 hours per week since June 30, 2014.

Participation – Who Can Be Covered

An employee is eligible for plan coverage if the employee has been determined by the MEBP employer to be a “full-time” status employee (see definition above)* for health plan purposes only, in accordance with the MEBP employer’s Policy for Determining Full-time Employment Status Under Internal Revenue Code Section 4980H, attached to the summary plan description as Appendix A.

*The definition of “full-time” status employee applies to this plan only. It does not define employment status for any other employee benefit plan provided by the MEBP employer and does not refer to employment status for any other employment purposes.

An employee who is an eligible grandfathered employee (see definition above) in accordance with the MEBP employer’s eligibility criteria for grandfathered employees outlined in Appendix B, Grandfathered Eligible Employees, which is attached to the summary plan description, is also eligible to be covered by the plan. Grandfathered employees are eligible to continue plan coverage as long as they continue to satisfy the eligibility criteria outlined in Appendix B.

Enrollment – When Coverage Starts

Initial Enrollment – Newly Hired “Full-time” Status Employees
A newly hired employee who has been determined by the MEBP employer to be a “full-time” status employee for health plan purposes only, in accordance with Appendix A, is eligible for plan coverage on the first day of employment.

Change in Employment Status
An employee who has not been eligible for plan coverage may enroll following a change in employment status that results in eligibility for coverage as a “full-time” status employee for health plan purposes only, as determined by the MEBP employer in accordance with Appendix A. Coverage will be effective as outlined in Appendix A.
**Annual Open Enrollment Period**
In addition to late enrollees, employees not enrolled in the plan who are determined by the MEBP employer to be “full-time” status employees for the new plan year for health plan purposes only, in accordance with Appendix A, have the opportunity to enroll in the plan during the annual open enrollment period. Coverage for an individual who enrolls during the annual open enrollment period will be effective the following July 1.

**How Your Health Coverage Works**

**Total Annual Out-of-Pocket Maximum**
The total annual out-of-pocket maximum now includes outpatient prescription drug copays in addition to deductibles, coinsurance, and office visit copays. The total annual out-of-pocket maximum for in-network services has been increased to $6,600 per person and $13,200 per family for the 2016 plan year.

Copayments for outpatient prescription drugs are also applied to a separate annual out-of-pocket maximum for prescription drug copayments ($3,000 per covered person). After you have paid the annual maximum out-of-pocket cost for prescription drug copayments or the total annual out-of-pocket maximum, whichever occurs first, the plan will pay all further eligible prescription drug expenses for that plan year.

**Covered Services**

**Preventive Care Services – Adult Preventive Care Services**
Covered adult preventive care services now include risk reducing breast cancer medications (Tamoxifen or Raloxifene) for women without a cancer diagnosis who are determined by their physician to be at increased risk for breast cancer and at low risk for adverse medication effects.

**Spinal Manipulations**
The annual visit limit for spinal manipulations has been increased to 25 visits per plan year.

**Therapy and rehabilitation Services**
The annual visit limit for physical medicine, speech therapy, and occupational therapy received on an outpatient basis has been increased to 25 visits per plan year.

**When Coverage Ends**
Plan coverage for a “full-time” status employee ends the day the employee ceases to be eligible for coverage under the plan as a “full-time” status employee for health plan purposes, due to a change in employment status, as determined by the MEBP employer in accordance with Appendix A, unless the employee has elected early retirement and chooses to continue on the plan, according to the terms of the MEBP employer’s personnel policy in effect at the time of the employee’s retirement.

Plan coverage for a grandfathered employee ends the last day of the month in which the employee no longer meets the eligibility criteria for grandfathered employees, as determined by the MEBP employer in accordance with Appendix B.

**Outpatient Prescription Drug Rider**

**Compound Prescription Drugs**
The plan will not cover compound prescription drugs that cost less than $300 and include an ingredient not approved by the U.S. Food and Drugs Administration.

In addition, compound prescription drugs costing $300 or more require preauthorization through CVS Caremark to ensure the medical necessity and appropriateness of the prescription.

You or your physician may call CVS Caremark at (800) 294-5979 to determine if a specific compound drug costs $300 or more and requires preauthorization prior to purchase at a participating pharmacy or through mail order. If a compound prescription drug requires preauthorization, your physician must obtain authorization through CVS Caremark at (800) 294-5979 prior to the dispensing of the drug. If the compound prescription drug is determined by CVS Caremark to be medically necessary and appropriate, the drug will be dispensed.

If you purchase a compound prescription drug that is not covered by the plan or if you do not obtain prior approval for a compound drug costing $300 or more through CVS Caremark, there are no plan benefits and you will be responsible for the total cost of the drug.
Prescription Drugs Costing $5,000 or More
All prescription drugs costing $5,000 or more require preauthorization through Everence Insurance Company (Everence) to ensure the medical necessity and appropriateness of the drug. This requirement does not apply to specialty pharmaceuticals which are required to be approved through CVS Caremark as outlined in the Outpatient Prescription Drug Rider regardless of the cost.

You or your physician may call Everence at (800) 348-7468 to determine if a specific prescription drug costs $5,000 or more and requires preauthorization prior to purchase at a participating pharmacy or through mail order. If a prescription drug requires preauthorization, your physician must obtain authorization from Everence at (800) 348-7468 prior to the dispensing of the drug. If the prescription drug is determined by Everence to be medically necessary and appropriate, the drug will be dispensed.

If you do not obtain prior approval for a prescription drug costing $5,000 or more through Everence, there are no plan benefits and you will be responsible for the total cost of the drug.

Cost Sharing
Copayments for outpatient prescription drugs are applied to the annual out-of-pocket maximum for prescription drug copayments ($3,000 per covered person) and the total annual out-of-pocket maximum. After you have paid the annual out-of-pocket maximum for prescription drug copayments or the total annual out-of-pocket maximum, whichever occurs first, the plan will pay all further eligible prescription drug expenses for that plan year.