**Online Enrollment**
Benelogic 866-214-5525 https://wilmu.benelogic.com
info@wilmu.benelogic.com

**Medical**
Highmark BlueCross BlueShield 800-633-2563 www.highmarkbcbsde.com

**Prescription Drug (Bundled with Medical)**
Highmark BCBS Drug Coverage www.express-scripts.com
(Administered by Express Scripts)
Retail Pharmacy 800-451-6245
Mail Order Pharmacy 800-451-6245

**Discount Prescription Drug Card**
Trustscripts www.trustscripts.com

**Vision**
Superior Vision Services 800-507-3800 www.superiorvision.com

**Dental**
Dominion National 888-518-5338 www.dominionnational.com

**Life and Disability**
Mutual of Omaha www.mutualofomaha.com
Life and Accidental Death and Dismemberment (Basic & Voluntary) 800-775-8805
Short-term Disability 800-877-5176
Long-term Disability 800-877-5176

**EAP**
Health Advocate 866-695-8622 www.healthadvocate.com/wilmu

**Health Advocacy**
Health Advocate 866-695-8622 www.healthadvocate.com/wilmu

**403(b) Retirement Savings Plan**
TIAA-CREF 800-842-2252 www.tiaa-cref.org

**Flexible Spending Accounts**
TASC 800-422-4661 www.tasconline.com

**Voluntary Benefits**
AFLAC 800-992-3522 www.aflac.com
Please Note: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Wilmington University reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.
Eligibility Requirements

Full-time employees - You are eligible for coverage under the Plan if you are an active, full-time employee of Wilmington University residing in the United States. Please refer to the Wilmington University Employee Handbook for the complete definition of eligibility.

Dependents

- A lawful spouse as defined by applicable state law (unless legally separated);
- Any dependent child up to age 26, including a biological child, a step-child, a legally adopted child and a child for whom you or your Spouse are the legal guardian.

Coverage for dependents terminates when the child attains age 26. Coverage may extend beyond age 26 for disabled children who were enrolled prior to their 26th birthday.

Your dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your spouse are both covered under the Plan, you may each be enrolled as an Employee or be covered as a dependent of the other person, but not both. If you and your spouse are both covered under the Plan, only one parent may enroll your child as a dependent.

A dependent also includes a child for whom health care coverage is required through a ‘Qualified Medical Child Support Order’ or other court or administrative order. Wilmington University is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

To be eligible for coverage under the Policy, a dependent must reside within the United States.

Making Changes

You may make changes to your health care and other insurance benefit choices once a year during the open enrollment period. Generally speaking, elections for group health insurance are irrevocable for the plan year under Section 125 plans. However, the Internal Revenue Service (IRS) provides specific instances when an employee can make midyear election changes:

- Change in marital status.
- Change in number of dependents.
- Change in employment.
- Change in dependent eligibility due to plan requirements (e.g., loss of student status, age limit reached).
- Change in residence (e.g., employee or dependent moves out of plan service area).
- Significant cost changes in coverage.
- Significant curtailment of coverage.
- Addition or improvement to benefits package option.
- Change in coverage of spouse or dependent under another employer plan (e.g., spouse’s employer had no insurance coverage before but now offers a plan).
- Loss of certain other health coverage (e.g., plans provided by governmental or educational institutions).
- Health Insurance Portability and Accountability Act (HIPAA) special enrollment right events.
- Judgments, decrees or orders.
- Entitlement to Medicare or Medicaid.
- Change in hours worked to less than 30 hours per week on average if the employee and covered family members enroll in another plan providing minimum essential coverage. The employee is eligible for a special enrollment period to enroll in a qualified health plan through a marketplace/exchange. Employees and others covered must enroll in the plan by the first day after coverage ends under the employer plan. See, IRS Notice 2014-55 for details.

You must request a change in coverage through the Benelogic online benefits portal with 30 days of the qualifying event. Please also notify the Human Resources Department of your request.

Coordination of Benefits (COB)

Coordination of benefits applies if you or your covered dependents are insured by more than one health insurance plan. The plans coordinate with each other on payments so that your bills don’t get paid twice for the same medical service. COB follows carve-out rules listed below.

The order of payments is as follows:

- The plan that covers the patient as an employee is the primary plan; that means it pays first.
- The plan that covers the patient as a dependent is the secondary plan and pays second.
- When a dependent child is covered by the plan of more than one parent, generally the plan of the parent whose birthday falls earlier in the year is considered the primary plan. This is known as the “birthday rule.” It applies unless a court order says otherwise.

Section 125

Certain benefits described in this guide may be purchased with pre-tax payroll deductions. When you purchase benefits with pre-tax dollars, you reduce your taxable income. That means you have more money in your take-home pay and fewer taxes come out of your paycheck.

Pre-tax Note: When you pay for your dependent’s benefits on a pre-tax basis, you are certifying that the dependent meets the IRS’ definition of a dependent. If your children or spouse does not meet this standard, you may be liable to pay more taxes.
New for 2017!
Effective 3/1/17, Wilmington University is pleased to announce that there will be minimal rate increases for medical and dental plans. While there will be no plan design changes, the IPA-HMO plan name is being changed to Simply Blue EPO and will now have access to the Highmark EPO network. The EPO network includes all doctors in the current IPA network as well as access to a national network of BlueCross/BlueShield doctors. We will continue to offer the Simply Blue EPO 500 deductible plan as well. In addition, Highmark has several features to their health plans, such as telemedicine, wellness and identity theft tools.

Benefits and Features of Highmark BlueCross BlueShield of Delaware

Simply Blue EPO and Simply Blue EPO 500
With the Simply Blue EPO plans you have the freedom to make your own health care decisions by being able to go to the network physician or hospital of your choice with no requirement for physician referrals. You have access to thousands of primary care physicians and specialists in the local Blue Plan Preferred-Provider Organization (PPO) provider network. Members are not required to select a PCP to coordinate covered care, but it is recommended.

You have total support no matter what your health status including an exceptional range of health education offerings, online tools to help you make appropriate, informed care choices and 24-hour access to confidential health information and care decision support. This includes the assurance that no matter where you travel across the state and around the world, you have access to covered care.

Wilmington offers two health plans, the Simply Blue EPO and the Simply Blue EPO 500. Details of the plans are on the following pages.

Telemedicine
See a doctor on your time – virtual medicine helps you feel better faster! Virtual medicine allows you to connect with a doctor 24/7 using your computer, tablet or smartphone. Visit www.amwell.com or www.doctorondemand.com to register and download the app to get started. You may use either or both of these services, depending on availability of virtual doctors in your area.

Wellness Tools
Highmark allows you to take charge of your health with several online tools and resources, powered by WebMD®, a trusted name in health and wellness information. Highlights include, My Health Assistant, Health Education and Information, Blues on Call and Baby Blueprints. To find about more and to start using these tools, please visit highmarkbcbsde.com.

Identify Theft Protection
In a continued effort to serve its members, Highmark is offering all eligible members access to free identity protection services.

If you need identity repair assistance during the 2017 coverage year, the team at AllClear ID is ready and standing by to assist you. There is no action required on your part at this time. If a problem arises, simply call AllClear ID at 1-855-229-0079 and a dedicated investigator will work with you to recover any financial losses, restore your credit, and make sure your identity is returned to its proper condition.

If you want additional protection, you may enroll into AllClear Credit Monitoring at any time during the 2017 coverage year at no cost to you. This service offers additional layers of protection, including credit monitoring, a $1M identity theft insurance policy, and ChildScan services for minors.

If you’re interested in signing up, go to highmark.allclearid.com. Once you reach the secure site, you’ll be asked for your name, group number and e-mail address. Next, you’ll get an email with a redemption code and instructions on creating an online account. When enrolling, you’ll need to provide your name, contact information, Social Security number and the unique redemption code. You can also sign up by calling 1-855-229-0079, Monday – Saturday from 8AM to 8PM CST (Central Standard Time).

Blue Classic Traditional
The Blue Classic Traditional plan is closed to new enrollment.

Required Coverage of Preventive Services

The term “preventive services” refers generally to routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Under the law, group health plans must provide coverage of certain preventive health services—without cost-sharing—based on various agency and advisory committee recommendations and guidelines. Guidelines for preventive services are regularly updated to reflect new scientific and medical advances. As new services are approved, health plans will be required to cover them with no cost-sharing for plan years beginning one year later.

The following is a partial listing of preventive services required to be covered under Health Care Reform. A complete list of required preventive services is available from the U.S. Department of Health and Human Services. These services generally will be covered at no cost share, when provided in the Highmark National EPO network:

For Adults
- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colon cancer screening for adults over 50
- Immunization vaccines (doses, recommended ages, and recommended populations vary)
- Obesity and tobacco use screening
- Type 2 diabetes screening for adults with high blood pressure

For Women
- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (e.g., no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

For Children
- Autism screening for children at certain ages
- Blood pressure screening
- Alcohol and drug use assessment for adolescents
- Developmental screening for children under age 3
- Immunization vaccines from birth to age 18 (doses, recommended ages, and recommended populations vary)
- Lead screening for children at risk of exposure
- Obesity screening and counseling
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>IN-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>None</td>
</tr>
<tr>
<td><strong>PREVENTIVE MEDICAL SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Periodic Physical Exams</td>
<td>100% covered</td>
</tr>
<tr>
<td>Routine Annual GYN Exam, Mammogram, Sigmoidoscopy, Colonoscopy</td>
<td>100% covered</td>
</tr>
<tr>
<td>Routine Well-Child Care</td>
<td>100% covered</td>
</tr>
<tr>
<td>Immunizations</td>
<td>100% covered</td>
</tr>
<tr>
<td>Periodic Vision &amp; Hearing Exams</td>
<td>100% covered</td>
</tr>
<tr>
<td>Routine Pap Smear, Prostate Screening Antigen Test, and Lead Poisoning Screening Test (Lab charges apply)</td>
<td>100% covered</td>
</tr>
<tr>
<td><strong>TREATMENT OF ILLNESS OR INJURY</strong></td>
<td></td>
</tr>
<tr>
<td>Doctor’s Office Visit for Diagnosis &amp; Treatment</td>
<td>$5.00 per visit</td>
</tr>
<tr>
<td>Specialist/Referral Care</td>
<td>$15.00 per visit</td>
</tr>
<tr>
<td>Allergy Testing/Treatment</td>
<td>$5.00 per visit</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>100% covered</td>
</tr>
<tr>
<td>Imaging &amp; Machine Testing Services</td>
<td>100% covered</td>
</tr>
<tr>
<td>Physical/ Occupational Therapy</td>
<td>$5.00 per visit for up to 30 combined visits per calendar year</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>$5.00 per visit for up to 30 visits per calendar year</td>
</tr>
<tr>
<td>Radiation Therapy &amp; Chemotherapy</td>
<td>100% covered</td>
</tr>
<tr>
<td>Home/Nursing Home Visits</td>
<td>$25.00 per visit</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>100% covered for up to 30 visits per calendar year</td>
</tr>
<tr>
<td><strong>IN THE HOSPITAL</strong></td>
<td></td>
</tr>
<tr>
<td>Semiprivate Room &amp; Board (including intensive care, if medically appropriate)</td>
<td>$100 per day for five days (calendar year maximum of $500 per person, $1,000 per family), then covered at 100%</td>
</tr>
<tr>
<td>Physician’s &amp; Surgeon’s Services</td>
<td>100% covered</td>
</tr>
<tr>
<td><strong>SURGERY</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% covered (except sterilization which is $25.00 per procedure)</td>
</tr>
<tr>
<td><strong>MATERNITY</strong></td>
<td></td>
</tr>
<tr>
<td>Prenatal &amp; Postnatal Care</td>
<td>100% covered</td>
</tr>
<tr>
<td>Delivery: Hospital or Birthing Center &amp; Physician</td>
<td>$100 per day for five days, then covered at 100%</td>
</tr>
<tr>
<td><strong>EMERGENCY SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>$5.00 per visit</td>
</tr>
<tr>
<td>Hospital &amp; Outpatient Emergency Facilities</td>
<td>$100.00 per visit (waived if admitted)</td>
</tr>
<tr>
<td><strong>AMBULANCE</strong></td>
<td>$25.00 per occurrence</td>
</tr>
<tr>
<td><strong>OTHER SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Private Duty Nursing</td>
<td>100% covered for up to 240 hours per 12-month period</td>
</tr>
<tr>
<td>Prosthetic Devices and Durable Medical Equipment</td>
<td>80% covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>100% covered for up to 120 days per confinement</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100% covered for up to 100 visits per calendar year</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient, Partial Hospitalization and Intensive Outpatient Care</td>
<td>$100 per day (calendar year maximum of $500 per person $1,000 per family), then covered at 100%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$5.00 per visit</td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUGS</strong></td>
<td></td>
</tr>
<tr>
<td>Retail, 34-day supply</td>
<td>$20/$60/$80</td>
</tr>
<tr>
<td>Mail Order, 90-day supply</td>
<td>$40/$120/$160</td>
</tr>
</tbody>
</table>

1. Facility charges and professional services for transplants performed at Blue Distinction Centers for Transplants® (BDCT) facilities are covered at the in-network facility benefit level. For transplants performed at participating but non-BDCT facilities, charges are covered at a 20 percentage point reduction off the BDCT level. In the absence of a plan year coinsurance expense limit, member coinsurance associated with the benefit reduction is capped at $10,000 per transplant. Transplants performed at non-participating facilities are not covered. Other limits apply.

2. Facility charges and professional services for bariatric surgeries are subject to any in-network copay or deductible, then are covered at 50%. Coinsurance does not apply to any coinsurance expense limit. Member must meet eligibility criteria to qualify for surgery.

3. If an individual chooses a Preferred or Non-Preferred Brand drug when a Generic drug is available, he or she will have to pay the difference between the charge for the Preferred or Non-Preferred Brand drug and the Generic drug, plus the copay for the Generic Drug.

**Note:** The information provided is neither an offer of coverage nor medical advice. It is only a partial, general description of plan or program benefits and does not constitute a contract. In case of a conflict between your plan documents and this information, the plan documents will govern.
**SERVICE** | **IN-NETWORK**
--- | ---
Calendar Year Deductible | Individual: $500; Family: $1,500. Does NOT apply to Preventive Services
Out-of-Pocket Limit | Individual: $500; Family: $1,500

**PREVENTIVE MEDICAL SERVICES**
- Periodic Physical Exams: 100% covered
- Routine Annual GYN Exam, Mammogram, Sigmoidoscopy, Colonoscopy: 100% covered
- Routine Well-Child Care: 100% covered
- Immunizations: 100% covered
- Periodic Vision & Hearing Exams (with PCP): 100% covered
- Routine Pap Smear, Prostate Screening Antigen Test, and Lead Poisoning Screening Test (Lab charges apply): 100% covered

**TREATMENT OF ILLNESS OR INJURY**
- Doctor’s Office Visit for Diagnosis & Treatment: $15.00 per visit
- Specialist/Referral Care: $15.00 per visit
- Allergy Testing/Treatment: $15.00 per visit
- Laboratory Services: 100% covered
- Imaging & Machine Testing Services: 100% covered
- Physical/ Occupational Therapy: $15.00 per visit for up to 30 combined visits per calendar year
- Speech Therapy: $15.00 per visit for up to 30 visits per calendar year
- Radiation Therapy & Chemotherapy: 100% covered
- Home/Nursing Home Visits: $30.00 per visit
- Chiropractic: 100% covered for up to 30 visits per calendar year

**IN THE HOSPITAL**
- Semiprivate Room & Board (including intensive care, if medically appropriate): 100% covered
- Physician’s & Surgeon’s Services: 100% covered

**SURGERY**
- Outpatient: 100% covered

**MATERNITY**
- Prenatal & Postnatal Care: 100% covered
- Delivery: Hospital or Birthing Center & Physician: 100% covered

**EMERGENCY SERVICES**
- Physician’s Office: $15.00 per visit
- Hospital & Outpatient Emergency Facilities: $100.00 per visit (waived if admitted)
- AMBULANCE: $50.00 per occurrence

**OTHER SERVICES**
- Inpatient Private Duty Nursing: 100% covered for up to 240 hours per 12-month period
- Prosthetic Devices and Durable Medical Equipment: 100% covered
- Skilled Nursing Facility: 100% covered for up to 120 days per confinement
- Home Health Care: 100% covered for up to 100 visits per calendar year

**MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT**
- Inpatient, Partial Hospitalization and Intensive Outpatient Care: 100% covered

**PRESCRIPTION DRUGS**
- Retail, 34-day supply: Generic/Preferred Brand/Non-Preferred Brand: $20/$60/$80
- Mail Order, 90-day supply: Generic/Preferred Brand/Non-Preferred Brand: $40/$120/$160

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1 Benefits are subject to a CALENDAR year deductible of $500 per person ($1,500 per family). Three individuals must meet the deductible in order for the family deductible to be met.

2 Facility charges and professional services for transplants performed at Blue Distinction Centers for Transplants (BDCT) facilities are covered at the in-network facility benefit level. For transplants performed at participating but non-BDCT facilities, charges are covered at a 20 percentage point reduction off the BDCT level. In the absence of a plan year coinsurance expense limit, member coinsurance associated with the benefit reduction is capped at $10,000 per transplant. Transplants performed at non-participating facilities are not covered. Other limits apply.

3 Facility charges and professional services for bariatric surgeries are subject to any in-network copay or deductible, then are covered at 50%. Coinsurance does not apply to any coinsurance expense limit. Member must meet eligibility criteria to qualify for surgery.

4 If an individual chooses a Preferred or Non-Preferred Brand drug when a Generic drug is available, he or she will have to pay the difference between the charge for the Preferred or Non-Preferred Brand drug and the Generic drug, plus the copay for the Generic Drug.

Note: The information provided is neither an offer of coverage nor medical advice. It is only a partial, general description of plan or program benefits and does not constitute a contract. In case of a conflict between your plan documents and this information, the plan documents will govern.
To be sure your vision care needs are met, Wilmington University offers a vision plan for you and your family that is administered through Superior Vision Services, Inc. Under this plan you are able to obtain services from network private practice providers and retail chain providers. Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a Superior Vision participant.


**SUMMARY OF BENEFITS**

**Frequency of Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>12 months</td>
</tr>
<tr>
<td>Lenses</td>
<td>12 months</td>
</tr>
<tr>
<td>Frames</td>
<td>24 months</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>12 months</td>
</tr>
<tr>
<td>(in lieu of lenses and frames)</td>
<td></td>
</tr>
</tbody>
</table>

**IN-NETWORK**

**OUT-OF-NETWORK**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Covered in full after $15 co-pay</td>
<td>Plan pays up to: $34 for ophthalmologist $26 for optometrist</td>
</tr>
<tr>
<td>Lenses</td>
<td>Covered in full after $25 co-pay</td>
<td>Plan pays up to $26</td>
</tr>
<tr>
<td>Frames</td>
<td>$150 retail allowance</td>
<td>Plan pays up to $79</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$120 retail allowance</td>
<td>Plan pays up to $100</td>
</tr>
<tr>
<td>Fitting Exam Fee</td>
<td>Covered in full after $25 co-pay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Standard Contact lens</td>
<td>Covered in full after $25 co-pay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialty Contact lens</td>
<td>$50 retail allowance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

This benefit summary is for descriptive purposes only. It is not an agreement or a contract. For more detailed information, refer to your Summary Plan Description.
## SELECT DHMO SUMMARY OF BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Covered Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Annual Maximums</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Waiting Periods</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Diagnostic and Preventive</strong></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Oral Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing X-Rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semiannual (2) teeth cleaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical Fluoride Treatments for children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td></td>
<td>74%</td>
</tr>
<tr>
<td><strong>Basic Care</strong></td>
<td>Fillings - amalgam (silver) or composite (white)</td>
<td>70%-80%</td>
</tr>
<tr>
<td>Full and panoramic X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extractions, erupted tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major Restorative Care</strong></td>
<td>Prosthetics - crowns and bridges, dentures, relining of dentures</td>
<td>55%-70%</td>
</tr>
<tr>
<td>Periodontics - root planing and therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics - root canals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery - extraction of impacted teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td></td>
<td>45%-55%</td>
</tr>
<tr>
<td>Children and Adults</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This plan summary is for comparison purposes only. See your certificate of coverage for more details.

## CHOICE PPO HIGH & LOW OPTIONS SUMMARY OF BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Covered Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visit</strong></td>
<td></td>
<td>No Charge</td>
</tr>
<tr>
<td>Deductible (Individual / Family)</td>
<td></td>
<td>$50 / $150 (waived on Class I benefits)</td>
</tr>
<tr>
<td>Annual Maximums</td>
<td></td>
<td>$1,000</td>
</tr>
<tr>
<td>Waiting Periods</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>I. Diagnostic and Preventive</strong></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Oral Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing X-Rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semiannual (2) teeth cleaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical Fluoride Treatments for children</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>II. Basic Care</strong></td>
<td>Fillings - amalgam (silver) or composite (white)</td>
<td>80%</td>
</tr>
<tr>
<td>Full and panoramic X-rays</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Extractions, erupted tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontics - root planing and therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics - root canals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>III. Major Restorative Care</strong></td>
<td>Prosthetics - crowns and bridges, dentures, relining of dentures</td>
<td>50%</td>
</tr>
<tr>
<td>Oral Surgery - extraction of impacted teeth</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td><strong>IV. Orthodontics</strong></td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Children and Adults</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This plan summary is for comparison purposes only. See your certificate of coverage for more details.
Wilmington University provides Life and AD&D insurance benefits to protect your family in the event of your death while employed at the University. AD&D coverage is a benefit paid in the event of a dismemberment or if death is due to an accident.

You have the option to purchase, as reduced group rates, additional (voluntary) life insurance for yourself and your spouse and dependents.

**Basic Life and AD&D Insurance**
- Premiums paid by Wilmington University.
- Employee Benefit Amount: Equal to 2X your annual salary to a maximum of $350,000.
- Benefit Reduction Schedule: Benefits will reduce 65% at age 70+ and terminates at retirement.
- AD&D Benefit: Amount equal to your basic life insurance.

**Employee Voluntary Term Life Insurance and AD&D Insurance**
- Premiums paid by the employee.
- Benefit Amount: Increments of $10,000, the lesser of 5X basic annual salary up to a maximum of $500,000.
- Guarantee Issue Amount: 5X basic annual salary up to $170,000 for new hires only.
- Benefit Reduction Schedule: Benefits will reduce 65% at age 70+ and terminates at retirement.

**Spousal Voluntary Term Life Insurance**
- Premiums paid by the employee.
- Benefit Amount: Increments of $5,000, to a maximum of 100% of employee's benefit amount, up to $100,000.
- Guarantee Issue Amount: 100% of employee's benefit amount up to $50,000 for new hires only.
- Benefit Reduction Schedule: Benefits will reduce 65% at age 70+ and terminates at retirement.

**Dependent Child Voluntary Term Life Insurance**
- Premiums paid by the employee.
- Benefit Amount: Increments of $1,000 to a maximum of $10,000; minimum of $2,000.
- Guarantee Issue Amount: $10,000.

Spousal and/or Dependent Child coverage is only available if employee has elected Voluntary Life coverage.

**Evidence of Insurability**
Purchasing Voluntary Term Life Insurance for the employee and/or their spouse may require an Evidence of Insurability (EOI) form completed whether they are a new hire or if they are increasing coverage at the annual open enrollment.

An EOI will be required for any amount over the Guaranteed Issue limits.

**Eligible Dependents for Voluntary Term Life Insurance Coverage**
Your eligible dependents include:
- A spouse to whom you are legally married.
- A dependent child under age 26.

If a dependent child is mentally or physically challenged, coverage may be extended beyond these age limits.

**Portability of Coverage**
The Voluntary Term Life plans are fully portable, which means employees may keep coverage for themselves, their spouse and their dependents at affordable group rates when they leave Wilmington University, retire or reduce work hours.

**Conversion of Coverage**
The Basic and Voluntary Term Life plans are also fully convertible. This allows an employee to convert all or part of the employee life insurance coverage to an individual policy when insurance is terminated or reduced under certain circumstances. Evidence of insurability is not required, however application must be made to Mutual of Omaha within 31 days of the qualifying event to be eligible for conversion.

**Beneficiary Designations**
The employee will need to make a beneficiary designation for basic and voluntary term employee life insurance. The employee is automatically designated as the beneficiary for spousal and dependent voluntary term life insurance.

The life insurance plans are subject to limitations and exclusions. See your certificate of coverage for more details. If there is any discrepancy in the above summaries or in certificate from the official plan documents, plan documents will govern.
Short-term Disability

We recognize that illnesses or injuries can have a major impact on your life and finances. To ensure some of your income will continue if you are unable to work due to an illness or injury, Wilmington University provides short-term disability (STD) benefits for full-time, benefits-eligible employees.

The STD program provides benefits for up to 11 weeks. Benefits are payable for a non-occupational injury or illness. If a medical condition is job-related, it is considered Worker’s Compensation rather than STD.

The STD program is administered by Mutual of Omaha. In order to receive STD benefits, you must be under the regular care of a licensed treating physician who practices within the scope of his/her license, and your disability must be certified through Mutual of Omaha.

The benefit level is 60% of your normal weekly base rate of pay up to a weekly maximum of $2,500.

To initiate STD claims, please contact the Human Resources department.

- Premiums paid by Wilmington University
- Benefit Percentage: 60% of normal weekly base rate of pay to a maximum of $2,500
- Elimination Period: 14 days
- Benefit Duration: 11 weeks

Long-term Disability

Long-term disability (LTD) is a benefit that is administered through Mutual of Omaha. It is provided to all full-time, benefits-eligible employees, and provides supplemental income replacement if you continue to be disabled and unable to perform the material duties of your job.

LTD provides 60% of your before tax monthly earnings up to a maximum of $10,000 per month. LTD coverage would be effective after STD coverage has been exhausted and approved.

Payments may be reduced by other income sources such as government-provided disability benefits that an employee is eligible to receive. Such benefits are triggered by the employee’s disabling condition and are not age-based. These government-provided benefits include Social Security disability payments and workers’ compensation.

- Premiums paid by Wilmington University
- Benefit Amount: 60% of your salary, to a maximum of $10,000 per month
- Elimination Period: 90 days
- Benefit Duration: Age 70

Pre-existing Condition Limitation

LTD benefits will not be paid for a disability caused by a pre-existing condition during the first 12 consecutive months of coverage. A pre-existing condition is defined as a sickness or illness for which you received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines in the three months prior to your effective date. You may receive credit towards the waiting period for each month that you were covered under a previous LTD plan.

The STD and LTD Mutual of Omaha plans have the option to be structured in such a way as to provide monthly benefits that are income tax free for the entire period of disability. Employees can choose to participate in a “tax choice” option.
Wilmington University offers a 403(b) plan in which you may make voluntary pre-tax contributions toward your retirement into your own TIAA-CREF 403(b) retirement account. You are eligible to participate in the 403(b) plan if you are a full-time or part-time employee of Wilmington University who is identified as being one of the following: Full-time Staff, Full-time Faculty, Part-time Staff and/or Adjunct Faculty. You are not eligible to participate in the plan if any of the following apply: you are a non-resident alien, you are a student who works for our university as described in Section 3121(b)10 of the Internal Revenue Code and/or you are a leased employee or an independent contractor.

The IRS limits the annual contributions you can make to a 403(b) plan. For 2017, the limit is $18,000 for participants under age 50 and $24,000 for participants who become age 50 or older during the calendar year. A minimum contribution of $200 per year is required to participate in this plan. In addition, if you are making pre-tax salary deferral contributions to another 403(b), 401(k), Simple IRA, or SARSEP plan, the total you can contribute to all plans combined is the amount indicated above. You can make a change in or stop your contributions at any time.

Please be aware that plan and investment-related information, including current performance for your TIAA-CREF 403(b) plan’s investment options, is always available online. Go to [www.tiaa-cref.org/planinvestmentoptions](http://www.tiaa-cref.org/planinvestmentoptions) and enter your six-digit Plan Number. The Wilmington University Plan Number is 334396 for contributions prior to 10/1/2015 and 500872 for contributions after 10/1/2015.

If you have any questions about your TIAA-CREF 403(b) Retirement Plan, please call the Wilmington University Human Resources Office at 302-356-6867 or call TIAA-CREF directly at [800-842-2252](tel:8008422252).

**AFLAC**

Aflac can help to provide for an unpredictable future by paying cash benefits for well visits, illnesses and accidental injuries. Your own peace of mind and the assurance that your family will have help financially are great reasons to consider Aflac. Additional information is available through Human Resources.

**HEALTH ADVOCATE**

Wilmington University will continue to provide, at no cost to you, access to Health Advocate. Health Advocate, Inc. is an advocacy and assistance service company founded to specifically address many of the issues Americans encounter while accessing the healthcare and health insurance systems. Their expertise and relationships in the healthcare industry combined with their in-depth knowledge of health and related insurance policies and procedures, give them the know-how to act on your behalf. This benefit is for you, your spouse, your dependent children, parents and parent-in-laws. Health Advocate can be reached by calling [866-695-8622](tel:8666958622).

**EMPLOYEE ASSISTANCE PROGRAM**

Health Advocate offers free counseling, information, referrals and assistance with life issues for you and your family. Free counseling services are provided on a confidential basis. Please log on to [www.healthadvocate.com/wilmu](http://www.healthadvocate.com/wilmu) or call [1-866-695-8622](tel:18666958622) for assistance. You may also contact Human Resources for additional information.
Flexible Spending Accounts (FSAs) allow you to be reimbursed for medical and dependent care expenses—on a tax-free basis.

If you can anticipate your family’s health care and dependent care costs for the next plan year, you may lower your taxable income. Here is how it works. You agree to set aside a portion of your pre-tax salary in the account. The money comes out of your paycheck over the course of the year. The amount you contribute to the FSA is not subject to Social Security (FICA), federal, state, or local income taxes—effectively adjusting your annual taxable salary. Depending on your tax bracket, you may realize significant savings.

**Health Care Account**
The Health Care FSA reimburses you for medical care expenses not covered by your insurance plan with pre-tax dollars. Examples include deductibles, copayments and coinsurance. Your annual maximum contribution to the Health Care Reimbursement FSA is $2,600.

**Dependent Care Account**
The Dependent Care FSA lets you use pre-tax dollars toward qualified dependent care. The annual maximum amount you may contribute to the Dependent Care FSA per calendar year is $5,000 or $2,500 if married and filing separate tax returns. **NOTE:** If you are also receiving Wilmington University Daycare/Eldercare benefits, the combination of all dependent care benefits are subject to the $5,000 calendar year IRS maximum. You are responsible to ensure that your total family dependent care elections do not exceed IRS maximums.

**Use It or Lose It**
Consider your expenses carefully before you decide how much to contribute to each FSA account. If your eligible expenses for the calendar year turn out to be less than the amount you contributed to your FSA account, federal law requires that the unused balance be forfeited (the “Use it or Lose it” rule). So do not contribute more than you are reasonably certain you will use.

**Over-the-Counter (OTC) Drugs**
The IRS requires a doctor’s note or prescription for reimbursement of OTC products under the Health Care FSA. This requirement applies to items such as cough medicines and pain relievers. Submit a doctor’s prescription when you submit your claim.

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**COBRA**

Under federal law, active employees and their eligible dependents who lose their group coverage may be able to continue the same group benefits they have for up to 18 to 36 months by paying for it themselves. This is known as COBRA coverage.

COBRA coverage is not available to employees who lose their jobs because of gross misconduct.

Qualifying events for employees include voluntary/involuntary termination of employment and a reduction in the number of hours of employment. Qualifying events for spouses or dependent children include the same events cited above for employees, plus, the covered employee’s becoming entitled to Medicare; divorce or legal separation; death or the loss of dependent status under the plan rules.

Upon termination or other COBRA qualifying event, the former employee and any other Qualified Beneficiaries (QBs) will receive COBRA enrollment information.

If a QB chooses to continue group benefits under COBRA, he or she must complete an enrollment form and return it to the Plan Administrator with the appropriate premium. Upon receipt of the premium payment and enrollment form, your coverage will be reinstated. Thereafter, premiums are due on the first of the month. If premium payments are not received in a timely manner, federal law stipulates that your coverage will be cancelled after a 30-day grace period.

If you have any questions about COBRA or the Plan, please contact the Plan Administrator or Human Resources.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator’s representatives conflict, the Plan document will govern.
Parental Leave Policy

Full-time, benefits-eligible employees may be eligible for two weeks of paid parental leave to bond and care for newborn and/or adopted child(ren). Parental leave must be utilized within the first 12-weeks following the birth or placement for adoption and must be utilized in increments of at least one (1) full week at a time. Any unused paid parental leave will be forfeited at the end of the 12-week eligibility period. Wilmington University will maintain all benefits during the paid parental leave period and normal employee contributions will continue to be deducted. Paid parental leave taken under this policy will run concurrently with leave taken under the FMLA, as applicable. In no case will the total amount of leave, whether paid or unpaid, granted to the employee under the FMLA exceed the maximum leave allowed during the 12-month FMLA period. Please contact the Human Resources office at least 30 days prior to the proposed date of the leave to apply.

Comprehensive Health Assessment Program

Wilmington University is offering benefits-eligible employees a FREE Comprehensive Health Assessment through CardioKinetics Inc. This program provides a simple biometric screening, a consultation with an Exercise Physiologist and an online Health Risk Assessment (HRA) to provide you with valuable information on how to prevent chronic diseases and maintain your good health. This is a confidential screening and your individual results will not be shared with Wilmington University.

CardioKinetics manages our New Castle Campus Employee Wellness Center, and provides health and fitness consultation services available to all benefits-eligible employees. CardioKinetics Inc. is a preventive medicine company, established in 1979, that provides health solutions to many different groups and organizations throughout the country. CardioKinetics evaluates health risk factors and helps clients take steps to improve their overall health. CardioKinetics is passionate about “Producing healthier people, one at a time.”

Wilmington University cares about YOU! This comprehensive health assessment program will provide you with the KNOWLEDGE and POWER to take control of your health. This assessment will inform you of your current health risk factors and what portion of that risk you can control by modifying your lifestyle.

Please contact Human Resources for more information.

Other Wellness Initiatives

Throughout the year, Wilmington University offers a variety of health and wellness based incentives for employees. This includes onsite yoga, a running club, TRX training, monthly Fit Stops and wellness challenges, flu shots, blood drives, and fitness center discounts.

Highmark, our health plan carrier, has discounts for members as well as numerous wellness tools and resources on their website, www.highmarkbcbsde.org.

Please note: Not all programs are available at all locations. Please contact Human Resources for more information.

Notice Regarding The Wilmington University Employee Wellness Program

The Wilmington University Employee Wellness Program (managed by CardioKinetics, Inc.) is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or “HRA” that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which will include a blood test for glucose, cholesterol, and triglyceride levels. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive for meeting specific criteria. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain wellness program health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Human Resources Department.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the
wellness program and Wilmington University may use aggregate information it collects to design a program based on identified health risks in the workplace, the aggregate report will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is CardioKinetics, Inc. in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Karen Ann Sheats, Human Resources Director at karen.a.sheats@wilmu.edu.

Glossary of Terms

**After-tax** - An after-tax basis means that the price of an option is deducted from your paycheck after taxes are withheld.

**Annual out-of-pocket maximum** (also known as Stop-Loss) - The maximum amount you will pay for eligible in-network medical and prescription expenses each year before your plan begins to pay 100% of all eligible health care expenses. There is no out-of-pocket maximum for out-of-network care.

**Before-tax** - A before-tax basis means you pay no federal income tax on the price to buy benefit options. The price for these options is withheld from your pay before tax—that is, before any federal, and most state and local, taxes are withheld.

**Beneficiary** - The person, trust, or estate that will receive the benefit payment from an insurance plan in the event of your, or a covered dependent’s, death.

**Coinsurance** - Typically expressed as a percentage. It is the percent you pay for prescription drugs or medical services after you’ve paid your deductible (if any).

**Deductible** - The amount you pay each year before the plan begins to pay benefits. Deductibles run on a calendar year.

**Evidence of Insurability** - Required under certain circumstances to provide your life insurance carrier with proof of your good health.

**Explanation of Benefits** - A statement from your carrier indicating services billed, charges for those services, the payment the carrier is making, and your individual or family deductible status, as applicable. An EOB may not be generated unless there is a balance for which the patient is responsible.

**Network** - A group of doctors, hospitals, and other health care providers that has agreed to provide high-quality services at a reduced rate and to comply with cost-effective health care management practices. Networks are maintained by the carrier, not Wilmington.

**Qualifying life event** - Qualifying life events refer to life status changes, defined by federal law, that prompt changes in personal data or benefit changes. Since many benefits are paid with before-tax dollars, limits are established for when these benefits may be changed.

**Reasonable & Customary Charges (R&C)** - The usual amount a doctor or other health care provider charges in the area in which the services are rendered for the same or a similar treatment, service, or supply. You pay expenses that are in excess of the R&C charge. Sometimes the term “R&C” is used interchangeably with “UCR”, which translates to “Usual, Customary, and Reasonable.”
Health Insurance Portability Accountability Act of 1996 Notice (HIPAA)

HIPAA is a federal law which was designed to protect health insurance coverage for employees and their families when they change or lose a job. The law also protects you from the unauthorized use and dissemination of your “protected health information” which includes your name, social security number, date of birth, health insurance plan enrollment and any information about your diagnosis or claim history. A copy of this Notice is available to you at any time, free of charge, by request through your employer.

Mental Health Parity and Addiction Equity Act

This act expands the mental health parity requirements under federal law by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan. In other words, there are no separate cost sharing requirements that apply only to mental health or substance abuse disorder benefits. A medical plan needs to offer substantially the same benefits for treatment of mental health and alcohol and drug abuse as medical and surgical benefits.

Women’s Health and Cancer Rights Act

The Women’s Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies.

Coverage must include: All stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or co-pays and co-insurance amounts.

Newborns’ and Mothers’ Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

For plan participants residing in California, the following maternity minimum stay provisions also apply: If the hospital stay is less than 48 hours after a normal vaginal delivery or less than 96 hours after a cesarean delivery, this plan will cover a follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The treating physician, in consultation with the mother, shall determine whether this visit shall occur at home, in a medical facility, or at the physician’s office.

Coverage Extension Rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

continued
Qualified Medical Child Support Order (QMCSO)
QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an “alternate recipient’s” right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An “alternate recipient” is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Michelle’s Law
Michelle’s Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

The continuation of coverage applies to a dependent child’s leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan.

Coverage will be continued until:
1) one year from the start of the medically necessary leave of absence, or
2) the date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

Medicare Part D Notice
The prescription drug plan is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Genetic Nondiscrimination
The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mandatory Insurer Reporting Law
Employees are required to provide Social Security numbers for all dependents enrolled in the medical plan. You will be asked to enter Social Security numbers for all dependents you enroll on your medical plan. The reason for this requirement is the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMESA). This law requires that providers of group health plans must report certain information (Social Security numbers of plan participants) to the Secretary of Health and Human Services (HHS) to determine Medicare entitlement. The reporting party will be the insurer or third-party administrator, or plan administrator or fiduciary if the plan is self-insured and self-administered. The law also provides penalties for noncompliance. This law became effective on January 1, 2009.

HIPAA Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information contact Human Resources.
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, 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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Health Insurance Marketplace Coverage Options and Your Health Coverage

When key parts of the health care law took effect in 2014, there became a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November for coverage starting January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage.
Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an aftertax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.