### 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 (Administered by Express Scripts)
www.express-scripts.com
- 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 Dental Services
888-518-5338
www.dominiondental.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

### COBRA
TASC
800-422-4661
www.tasconline.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 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. In addition, 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. WU 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 insurance benefit choices once a year during the open enrollment period. The only other time you can change medical coverage or enroll your spouse and/or children to your medical, dental, and vision coverage is if you have a qualifying event. Examples of qualifying events include marriage, birth, death. Coverage will be effective on the actual date of birth or adoption. If you get married or lose your other coverage, coverage will be provided within (30) days of the qualifying event.

You may also change your elections for health coverage under the following circumstances:

• a court order requires that your child receive accident or health coverage under this plan or a former spouse’s plan;

• you, your spouse, or dependent becomes entitled to Medicare or Medicaid;

• you have a Special Enrollment Right as defined by the IRS;

• there is a significant change in the cost of your coverage or your spouse’s group coverage from his or her employer.

You must request a change in coverage within 30 days of the qualifying event and notify the HR Department.

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.
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.

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 if there is a balance.

• 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. For example, Emma is the daughter of Jean and Harry Townsend. Jean’s birthday is May 24 and Harry’s is February 17. Harry’s plan covers Emma as the primary plan.

Special Enrollment Rights

If you decline enrollment in medical coverage features of the Plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the medical coverage features of this Plan, provided that you request enrollment within 30 days of your other coverage ending. If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you will be given the opportunity to provide details concerning your situation to preserve your special enrollment rights under the Plan in the future. 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 in the medical coverage features of this Plan, provided you request enrollment within 30 days of the marriage, birth, adoption or placement for adoption.

IRS Notice Permits Additional Election Changes for Health Coverage

For the plan year beginning on or after January 1, 2015, all cafeteria plans will allow an employee to prospectively revoke an election of coverage under a group health plan that is not a health FSA and that provides minimum essential coverage (as defined in § 5000A(f)(1) of the Affordability of Care Act) provided the following conditions are met.

Conditions to allow an election change for a reduction in employment hours:

1. The employee has been in an employment status under which the employee was reasonably expected to average at least 30 hours of service per week and there is a change in that Employee’s status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the group health plan; and

2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions to allow an election change for exchange enrollment:

1. The employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace’s annual open enrollment period; and

2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Employer may rely on the reasonable representation of an employee that they have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the time limits described above.
Simply Blue EPO (EPO 100)

With an exclusive provider organization (EPO) plan, you’ll be able to select doctors and hospitals from the Highmark Blue Cross Blue Shield network of providers without referrals – in Delaware or across the country. Coverage from non-preferred providers is only available in certain situations, such as an emergency. 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.

BlueCare IPA HMO (Primarily DE providers)

With an IPA plan, all of your basic medical care is provided by your primary care physician (PCP), who will refer you to specialists and hospitals if you need them. A Health Maintenance Organization (HMO) plan usually has the lowest out-of-pocket costs. HMOs require that the member select a primary care physician, generally a family practitioner, internist or pediatrician, who is part of the plan’s network. There are generally small copayments and no claims to file. In an HMO, a referral is required from the primary care physician to see any specialist in its network except an OB/GYN. Benefits are only paid for in-network services.

To locate a network provider, visit Highmark Blue Cross Blue Shield’s web site at [www.highmarkbcbsde.com](http://www.highmarkbcbsde.com) and click on “Find a Doctor or RX”. You can also call Highmark’s Customer Service Center at 800-633-2563.

BlueClassic (Comprehensive 100)

The Comprehensive 100 plan has been closed to new enrollment.

Women’s Preventive Health Benefits

As you may know, the Affordable Care Act (ACA, or Health Care Reform law) includes changes that are being phased in over a number of years. The latest set of changes includes additional benefits for certain Women’s Preventive Health Services.

All of the following women’s health services are considered preventive (some were already covered).

These services generally will be covered at no cost share, when provided in network:

- 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 (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

QUESTIONS CONCERNING THE MEDICAL OR PRESCRIPTION DRUG BENEFITS?
CALL HIGHMARK BCBS AT 800-633-2563
<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></td>
</tr>
<tr>
<td>AMBULANCE</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  
Outpatient | $15.00 per visit  
**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  

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.

To locate a network provider visit Superior Vision’s Web site at [www.superiorvision.com](http://www.superiorvision.com) and, click on “Locate a Provider”. You can also call Superior Vision’s Customer Service Center at 800-507-3800.

### 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**

- Exam: Covered in full after $15 co-pay
- Lenses: Covered in full after $25 co-pay
- Frames: $150 retail allowance
- Contact Lenses (in lieu of eyeglasses): $120 retail allowance
- Fitting Exam Fee: Covered in full after $25 co-pay
- Standard Contact lens: $50 retail allowance
- Specialty Contact lens: Not covered

**OUT-OF-NETWORK**

- Exam: Plan pays up to:
  - $34 for ophthalmologist
  - $26 for optometrist
- Lenses: Plan pays up to:
  - $26
  - $39
  - $49
- Frames: Plan pays up to $79
- Contact Lenses: Plan pays up to $100
- Fitting Exam Fee: Not covered
- Standard Contact lens: Not covered
- Specialty Contact lens: Not covered

*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 PLAN 605XS SUMMARY OF BENEFITS**

<table>
<thead>
<tr>
<th></th>
<th>Covered Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visit</strong></td>
<td>$10 Copay</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Annual Maximums</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Waiting Periods</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Diagnostic and Preventive</strong></td>
<td>100%</td>
</tr>
<tr>
<td>Oral Examination</td>
<td></td>
</tr>
<tr>
<td>Bitewing X-Rays</td>
<td></td>
</tr>
<tr>
<td>Semiannual (2) teeth cleaning</td>
<td></td>
</tr>
<tr>
<td>Topical Fluoride Treatments for children</td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td>65%</td>
</tr>
<tr>
<td><strong>Basic Care</strong></td>
<td>60%-75%</td>
</tr>
<tr>
<td>Fillings - amalgam (silver) or composite (white)</td>
<td></td>
</tr>
<tr>
<td>Full and panoramic X-rays</td>
<td></td>
</tr>
<tr>
<td>Extractions, erupted tooth</td>
<td></td>
</tr>
<tr>
<td><strong>Major Restorative Care</strong></td>
<td>55%-70%</td>
</tr>
<tr>
<td>Prosthetics - crowns and bridges, dentures, relining of dentures</td>
<td></td>
</tr>
<tr>
<td>Periodontics - root planing and therapy</td>
<td></td>
</tr>
<tr>
<td>Endodontics - root canals</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery - extraction of impacted teeth</td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td>45%</td>
</tr>
<tr>
<td>Children and Adults</td>
<td></td>
</tr>
</tbody>
</table>

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

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**ACCESS PPO HIGH & LOW OPTIONS SUMMARY OF BENEFITS**

<table>
<thead>
<tr>
<th></th>
<th>High Option</th>
<th>Low Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visit</strong></td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td><strong>Deductible (Individual / Family)</strong></td>
<td>$50 / $150</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Annual Maximums</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Waiting Periods</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic and Preventive</strong></td>
<td>100%</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>Basic Care</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Fillings - amalgam (silver) or composite (white)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full and panoramic X-rays</td>
<td></td>
<td></td>
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<tr>
<td>Extractions, erupted tooth</td>
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<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>Major Restorative Care</strong></td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Prosthetics - crowns and bridges, dentures, relining of dentures</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>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

This plan summary is for comparison purposes only. See your certificate of coverage for more details.
In the event of your death, Wilmington University offers life insurance benefits that protect your family financially. Through Mutual of Omaha, AD&D is a benefit paid in the event of dismemberment or as an addition to your life insurance if death results from an accident. You have the option to purchase, at reduced group rates, additional (voluntary) life insurance for not only yourself, but 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.

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.

The Mutual of Omaha plan has 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.

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
- Employees must be working at least 30 hours per week

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.
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 2016, 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 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.

**AFLAC**

Aflac enables you to take charge and 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.

**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/members or call 1-866-695-8622 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 $2,550.

**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.

**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.

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 CardioKineti cs Inc. This program provides a simple biometric screening, a consultation with an Exercise Physiologist and an online Health Risk Assessment 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.

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

Wilmington University cares about YOU! This comprehensive health assessment 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 information on their website www.highmarkbcbsde.org

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

**Emergency** - A life-threatening, sudden, and serious medical problem such as a stroke, heart attack, serious injury, acute asthma attack, poisoning, or convulsions.

**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 of 1996 (Newborn’s Act)

Group health plans and health insurance issuers generally may not, under federal law, 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 cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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.

Medicare Part D Notice

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

Certificate of Creditable Coverage

Must be provided automatically upon losing group healthplan coverage, becoming eligible for COBRA coverage and when COBRA coverage ceases. An individual may also request a Certificate of Creditable Coverage free of charge anytime prior to losing coverage and within 24 months of losing coverage.

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.