ST. THOMAS UNIVERSITY

Leaders for Life



EMPLOYEE BENEFITS OVERVIEW

January 1, 2020 through December 31, 2020

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

Welcome to St. Thomas University

New Hire Coverage

As a new employee, it is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event.

Benefits Effective: 1st of the month following 30 days from date of hire

Content

This guide is meant to provide basic benefit plan information. Every attempt has been made to ensure that the information included in this guide is accurate. For additional details and specific information, please contact the vendor or review the Summary Plan Description (SPD) for each plan. SPDs are available by contacting the Human Resources department at (305) 628-6514 for a printed version.

DISCLAIMER: *St. Thomas University reserves the right to terminate, suspend, withdraw, amend or modify the plan in whole or in part at any time. Further, St. Thomas University, reserves the right to terminate or modify coverage for any group of employees, active or retired and their dependents or a class of dependents at any time.*

ENROLLMENT & ELIGIBILITY

ENROLLMENT OPPORTUNITIES

There are three opportunities to make benefit elections:

- when you are hired as a new employee,
- when you have a Qualified Event Status Change (QE), or
- during open enrollment

Option 1 - Hired as a New Employee

If you're a newly hired regular full-time employee, you must enroll in your plan selections when you become eligible. If you do not enroll when you become eligible, you must wait until the next open enrollment period to enroll. Choose your options carefully. Once enrolled, you cannot make changes until the next open enrollment period unless you have a QE.

Option 2 - Qualifying Event (QE) Status Change

If you have a Qualifying Event Change, you have **30 days** from the date of the QEC to make any changes to your benefits. Currently, the following are some examples of valid Qualifying Events:

- ✓ marriage, divorce or legal separation
- ✓ birth, adoption or legal guardianship of a child
- ✓ death of a spouse or dependent child
- ✓ dependent losing eligibility status due to age, student status or marriage.
- ✓ change in employment status for you or your spouse if it effects your benefit eligibility.
- ✓ a change corresponding with a spouse's open enrollment period at his or her place of employment.

We will consider a spouse who has an Open Enrollment or New Hire Eligibility election option through their employer as a Qualifying Event for any employee to terminate their coverage with proof of new coverage.

Option 3 - Open Enrollment

We hold open enrollment each year to give you the opportunity to review benefit plan options and make changes for the following plan year.

ELIGIBLE DEPENDENTS:

Your legal spouse.

Your eligible children up to age 26

- "Children" are defined as your natural children, stepchildren, legally-adopted children and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support.

Additional Dependent Eligibility Requirements for Dependents.

Florida law also provides that an adult child is eligible for extended dependent coverage up to the end of the calendar year he or she reaches the age of 30, if the child:

- Is a resident of Florida or a full-time or part-time student;
- Is unmarried and does not have a dependent of his or her own; and
- Is not provided coverage under any other group, blanket or franchise health insurance policy or individual health benefits plan, and is not entitled to Medicare benefits.

ONLINE ENROLLMENT– New Users

How to Make Elections
The enrollment process is Simple with **BBMyBenefits.EmployeeNavigator.com**

EMPLOYEE BENEFITS WEBSITE: **BBMyBenefits.EmployeeNavigator.com**

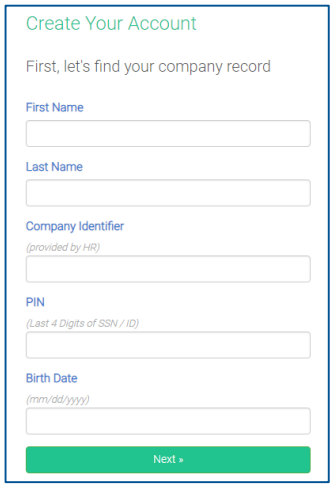
REGISTERING:

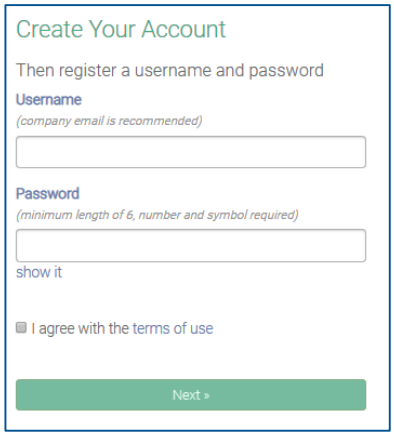
Click "**Register as a new user"**

You will need the following information

- **First Name**
- **Last Name**
- **Company Identifier** = **S.T.U**
- **PIN** = Last 4 digits of your **SSN**
- **Birth Date**

HELPFUL TIP: Use an easy to remember username such as an email.
Passwords require at least 6 characters, a special character (!, @, #, $, %, *) and a number.





Complete the registration by creating your username and password. Please be sure to write down your login information for future use.

Welcome! We're excited to have you on our team.

Say hello to your benefits management too! Here you'll have 24/7 access to detailed information about our employee benefits program, company documents, interactive tools, and more! Click continue to find out what HR needs from you before you begin navigating your personalized employee profile.

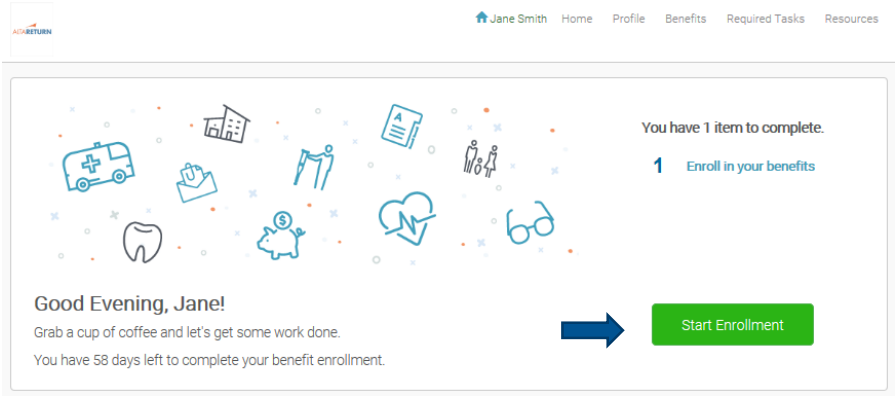
Continue

ONLINE ENROLLMENT

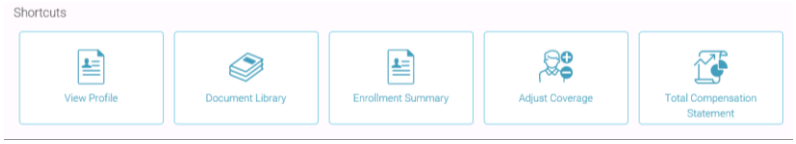
Welcome to **St. Thomas University** online open enrollment benefits website! As you know, your benefits are an important part of your overall compensation. Our online benefits enrollment system is simple and convenient to help make enrollment faster and easier than ever before!

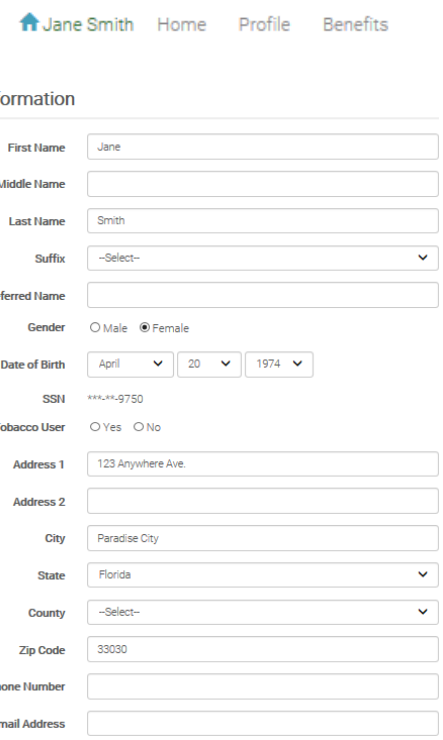
Before You Begin: If adding eligible dependents, you will need to include their Social Security # and date of birth.

Getting Started: Once you have registered you can access the website and can continue to the online enrollment site
To start your enrollment click "Start Benefits" on your **HOME SCREEN**



The home screen contains links to your Employee Benefits Package Information, Required Tasks and Company Resources Library along with Compliance Documents such as the Summary of Benefits Coverage. The "Start Benefits" bar on the right side of the screen will begin your Enrollment process starting with your Personal and Dependent information.

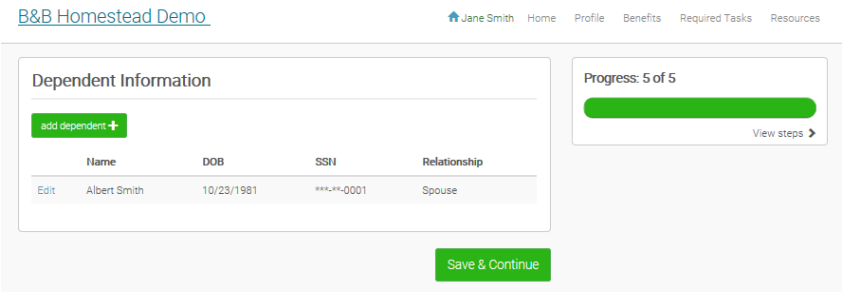




HELPFUL TIP FOR SPANISH SPEAKERS: Click on your username on top right corner of screen and choose "Español" to switch to Spanish translation.

PERSONAL INFORMATION — The first screen in the enrollment process will give you the opportunity to update your personal information such as phone or address, as well as add any dependents you want to enroll into a plan. Update your personal information first and then select **"Save & Continue".** You will automatically be prompted to add a dependent or save and continue to next screen.

TO ADD DEPENDENTS — Click on "add dependent". A window will pop up for you to enter the applicable information. You may add as many dependents as necessary. Once completed with the dependents, click "Save & Continue".



IMPORTANT: BE SURE TO "SAVE & CONTINUE" AT EACH SCREEN

Deductible: The amount you pay each year before a plan pays benefits for services that require co-insurance. The deductible may not apply to services with a copay.

Coinsurance: The percentage of the cost you pay for certain services once you meet your deductible. Example, a plan with an 80%/20% coinsurance will pay at 80% once you have met your deductible. The member responsibility will be 20% up to the Out-of-Pocket maximum.

Co-payment: The fixed dollar amount required to be paid by a member to a provider when services are rendered.

Out-of-Pocket Maximum: This is the most you will pay for covered expenses in a calendar year. Once the out-of-pocket maximum is reached, the insurance company will pay 100% of all services rendered for the remainder of the plan year **including** prescription drugs.

Specialist: A physician who limits practice to specific services (i.e. surgery, radiology), certain body systems (i.e. cardiology, orthopedics), or types of diseases (i.e. allergy, oncology)

Inpatient: A patient who is admitted for an overnight stay in a medical facility (i.e. hospital).

Outpatient: A patient who receives treatment at a hospital or an outpatient facility without being admitted overnight.

Pre-Certification of Care: Authorization for a specific medical procedure before it is done or for admission. **IT IS THE MEMBERS' RESPONSIBILITY TO ENSURE ALL PROPER AUTHORIZATIONS WERE GATHERED BY THE PROVIDER PRIOR TO HAVING SERVICES RENDERED**.

Independent Diagnostic Testing Facility (IDT) or Ambulatory Surgical Center (ASC): An Independent health care center which now delivers many diagnostic, therapeutic and surgical procedures formerly provided only in hospitals.

Urgent Care Centers: Centers designed to evaluate and treat conditions that are not severe enough to require treatment in a hospital emergency department but still require treatment beyond normal physician office hours or before physician appointment is available.

In-Network Care: The group of providers who are approved for services and are available for treatment under the insurance company's plan contract. When you seek services from a participating provider, you receive a higher level of benefits. This means when you use an in-network provider, you substantially reduce the amount you pay for medical services. Participating providers also take care of filing your claim directly with the insurance company.

Reasonable & Customary (R&C): The maximum amount a plan will consider eligible for reimbursement, based upon prevailing fees in a geographic area.

Allowed amount: The charge that the insurance company determines is reasonable for a covered service. This amount may be determined by agreement between the provider and insurance company. The insurance company does not pay benefits on amounts that exceed the allowed amount. If you use an out-of-network provider who charges more than the allowed amount, you are responsible for coinsurance plus 100% of the charge that exceeds the allowed amount.

Coordination of Benefits (COB): Occurs when a person has health care coverage under more than one insurance plan. All plans require information from employees on other coverage that they or their dependents have from another health insurance carrier.

Emergency: Generally, a condition will be considered a true emergency under the plan if it is severe, begins suddenly or unexpectedly, requires care as soon as possible after the condition begins, and requires immediate treatment to avoid serious injury or death.

EMERGENCY ROOM vs URGENT CARE:

Emergency rooms and urgent care centers both offer after-hours care for unexpected medical situations that need immediate attention and determining which of these facilities is appropriate to your immediate medical needs can save you time and money.

Emergency rooms are equipped to handle life-threatening injuries and illnesses, and other serious medical conditions such as difficulty breathing or sudden, severe pain. Patients at the emergency room are triaged (sorted) according to the seriousness of their conditions. For example, a patient with severe injuries from a car accident would like be seen before a child with an ear infection, even if the child was brought in first.

Those who go to the emergency room with relatively minor injuries or illnesses often have to wait more than an hour to be seen, depending on the severity of the other patients' conditions.

Get familiar with the urgent care and walk-in clinics in your neighborhood before you need them by visiting www.mycigna.com.

If your medical need is more than urgent for example, characterized by chest pain, trouble breathing, bad bleeding or other symptoms that are serious or put your life at risk you should go straight to your local ER.

IMPORTANT TERMS TO KNOW PRESCRIPTION MEDICATIONS

Prescription Medications

Generic Drugs: Drugs that are labeled with the medication's basic chemical name and usually have brand-name equivalents. They have exactly the same active ingredients as and are therapeutically equivalent to brand-name drugs. They must meet the same FDA standards for safety, purity, strength and quality, and are generally less expensive.

Preferred Brand-Name Drugs: Brand-name drugs that do not have a generic equivalent. They generally cost less than non-preferred brand-name drugs.

Non-Preferred Brand-Name Drugs: Brand-name drugs which generally have either an effective generic equivalent and/or at least one preferred brand-name equivalent. They are therefore more expensive than generic and preferred brand-name drugs.

GENERIC vs BRAND, WHAT'S THE DIFFERENCE?

Generic medications may look different, but they provide the same level of quality, safety, and effectiveness as the name brand medicine for a lower price. Often two brand-name drugs (non-generic) can be used for the same problem. One may be less expensive than the other. That drug becomes a preferred drug, and the other becomes non-preferred. Check your Preferred Drug List (PDL) periodically, as it is updated quarterly. Sometimes the drug moves from the preferred list to the non-preferred list. If this happens, ask your doctor if he or she can prescribe a preferred drug that would cost you less money and work just as well for you.

Prior Authorization Medications—Some prescription medications require prior authorization before they can be covered under the prescription drug plan. Your doctor will need to provide more information about why these medications are being prescribed so the carrier can verify their medical necessity.

Medications with Quantity Limits—Some medications have limits on the quantities that will be covered under the prescription drug plan. Quantity limits are placed on prescriptions to make sure you receive the safe daily dose as recommended by the FDA and medical studies. When you go to the pharmacy for a prescription medication with a quantity limitation, your copayment will only cover the quantity allowed by the plan. You may still purchase the additional quantities, but you will pay the additional cost. The cost of the additional quantities will not count toward your annual out-of-pocket maximum.

Step Therapy—Step therapy is a process for finding the best treatment while ensuring you are receiving the most appropriate medication therapy and reducing prescription drug costs. Medications are grouped into two categories:

- **First-Line Medications:** These are the medications recommended for you to take first, usually generics, which have been proven safe and effective. You pay the lowest copayment for these.
- **Second-Line Medications:** These are brand name medications. They are recommended for you only if first-line medication does not work. You may pay more for brand name medications.

Stretching your healthcare dollars for medications

To help control drug expenditure increases, you need to take an active part in understanding your prescription drug benefit. The following suggestions can help you save money:

⇒ Ask if an over-the-counter medication would work as well as the prescription.

⇒ If your doctor prescribes a new medication, ask if they have samples. This will allow you to make sure the prescribed medication is right for you and can save you a co-pay or two!

⇒ If you take maintenance medications for ongoing medical conditions such as diabetes, high blood pressure or oral contraceptives, the carrier's mail-order pharmacy offers a convenient, discreet way to obtain your medications without leaving the comfort of your home. Under your carrier's medical plans, you can receive up to a 90-day supply for a discounted rate with no additional delivery fee. Simply ask your physician for a 90-day supply of your medication with refills, complete the necessary mail-order form and send in, your prescription will be filled and mailed to your home or location of choice.

These steps follow the most current and appropriate medication therapy recommendations. The carrier will review your records for step therapy medications when you go to the pharmacy to fill a prescription. If your prescription is for a step therapy medication, the pharmacy will search your prescription records for use of a first-line alternative.

PROGRAMS AVAILABLE TO YOU

CVS, Target, Walgreens & Wal-Mart also offer over 400 generic prescriptions for 30 day-supply of $4 and a 90 day supply for approx. $10.

Remember Do Not show your insurance ID card to receive the benefits, or you will be charged your Rx benefit co-pays.

Please visit the various websites for list of medications and locations, hours of operations and list of medications.

CVS Minute Clinic: www.cvs.com
Publix: www.publix.com
Walgreen's Take Care Clinic: www.walgreens.com
Wal-Mart Pharmacy: www.Walmart.com

Good RX: DOWNLOAD THE FREE APP. State Programs, manufacturer coupons and much more.

HOW TO STRETCH YOUR HEALTH CARE DOLLARS

AT THE DOCTOR'S OFFICE

- Ask your physician questions - you deserve information you understand completely.
- Ask your physician about home testing and monitoring devices (i.e. blood pressure, diabetes).
- Keep records of all appointments and outpatient visits which include the provider's name, procedures and tests performed and medications received or purchased.
- Keep track of any Explanation of Benefits (EOBs) you receive and compare them to your receipts and invoices.

WITH YOUR HEALTH PLAN

- Get an itemized bill for any hospital stay, and check it to ensure it reflects the care you received.
- Understand how your health plan works.

Look into freestanding surgical and diagnostic centers. If you need surgery, you might save money by having it performed at an ambulatory surgical center (a clinic that is not associated with a hospital) these sites usually charge less than hospitals or their outpatient surgical centers. Freestanding diagnostic centers are also available and tend to charge less for certain tests like MRI's, CAT scans, X-rays and bone density scans. But before you go, make sure the facility is in your plan's network and that your plan's benefits cover the service.

Retail & Urgent Care Centers for non-emergencies and the Emergency Room for true emergencies.

1 - Amwell / MDLive A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, which you can pick up at your local pharmacy.

2 - Retail / Convenience Health Clinic While these clinics lack the personal nature of seeing a family physician who knows your complete medical history, their appeal is the temporary relief when your doctor is not available and at a lower cost.

3 - Urgent Care Center If you need medical care when your regular doctor is not available, think about going to an urgent care center rather than a hospital emergency room. Two reasons to go to the urgent care center for non-emergencies are lower cost that the emergency room and getting care will almost certainly be faster than at the emergency room.

Conditions Commonly Treated:

- Bronchitis
- Cold/Flu
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus Problems
- Sore Throat

PREVENTATIVE CARE SERVICES: Certain preventive services are covered without charging a deductible, copayment or coinsurance when these services are provided by a network provider.

- Services may vary based on age, gender and health status.
- There may be services you had in the past that will now be covered as preventive, at no additional cost to you.
- **And, there may be services you received in the past that were considered preventive, that may no longer be covered as preventive under the new guidelines.**

IT'S IMPORTANT TO REVIEW YOUR PLAN DOCUMENTS FOR THE PREVENTIVE SERVICES INCLUDED IN YOUR SPECIFIC BENEFIT PLAN.

CODING TIP: Keep in mind that your provider must code these items and services as **PREVENTIVE** care in order for the Health Plan to cover them at 100%. During your office visit, be sure to remind your provider to code these services as preventative care.

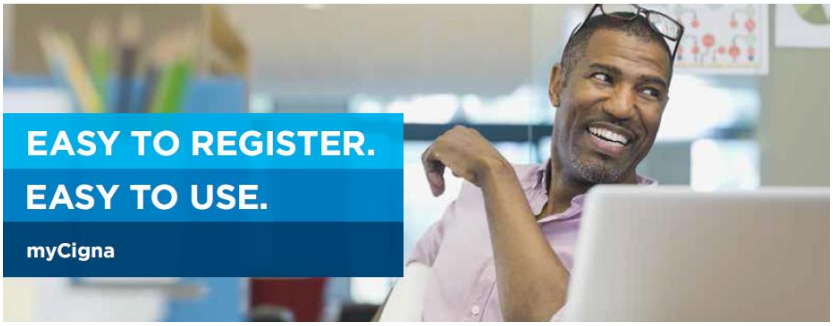
COLONOSCOPY COVERAGE TIP: Eligibility age: Per federal government mandates, the Health Plan will cover colonoscopies for plan members beginning at age 50 **(1 Preventative Colonoscopy every 10 years)**.

Diagnostic services are not covered under the preventive care benefit, but are covered under another portion of the medical benefit plan. Services are considered diagnostic care when a person:

- Had abnormalities found on previous preventive or diagnostic services that require further diagnostic services; or
- Had abnormalities found on previous preventive or diagnostic services that would recommend a repeat of the same service within a shortened time period from the recommended preventive screening time period based on age and gender

Examples: Diagnostic services - A patient had a polyp found and removed at a prior preventive screening colonoscopy. All future colonoscopies are considered diagnostic because the time period between future colonoscopies would be shortened.

CIGNA RESOURCES



It's easy to set up.
Download the **myCigna App** or visit **myCigna.com**.

1. **Launch** the **myCigna App** or go to **myCigna.com** and select "Register Now"
2. **Enter** your personal information
3. **Confirm** your identity
4. **Create** your security information and provide your primary email address for enhanced security protection and notifications
5. **Review**, then select "Submit"

Why do we ask you to provide your primary email address as part of the registration process? Email allows us to better protect the security of your information. We will send automatic alerts when your email or password is updated, and it can also be utilized for the Forgot User ID and Forgot Password functionality.

It's easy to find what you need.

› Find in-network doctors and medical services
› Manage and track claims
› See cost estimates for medical procedures
› Compare quality of care for doctors and hospitals
› Access a variety of health and wellness tools and resources

myCigna App users log in with just one touch.
Download the myCigna App and securely access your account with just a fingerprint on any compatible device.*

Health care professional directory
• Search for a doctor or health care facility from the Cigna national network and compare quality-of-care ratings
• Access maps for instant driving directions

ID cards
• Quickly view ID cards (front and back) for the entire family
• Easily print, email or scan right from a smartphone

Claims
• View and search recent and past claims
• Bookmark and group claims for easy reference

Drug search
• Look up and compare actual costs at over 60,000 pharmacies nationwide
• Find closest pharmacy location using GPS
• Research medications and dosages
• Speed-dial Cigna Home Delivery PharmacySM

Account balances
• Access and view health fund balances
• Review plan deductibles and coinsurance

Health wallet
• Store and organize all important contact info for doctors, hospitals and pharmacies
• Add health care professionals to a contact list right from a claim or directory search

CIGNA RESOURCES

Your medical plan includes telehealth services through Cigna Telehealth Connection, provided by Amwell and MDLIVE with 24/7/365 access to board-certified doctors and pediatricians by video chat or phone.

Frequently asked questions

What is telehealth?
Telehealth is the delivery of health-related services and information via telecommunications technologies, including telephones, smartphones and personal computers, for virtual consultations. Among the most significant benefits are ease of access, convenience, time savings and competitive cost.

What is Cigna Telehealth Connection?
Cigna Telehealth Connection is our telemedicine program that provides access to certain telehealth services as part of your employer's medical plan through Cigna. It includes live appointments with board-certified doctors via secure video or phone who are able to diagnose and prescribe, when appropriate. Customers are able to choose the time and day that works best for them with medical telehealth services available 24/7/365.

Is telehealth a safe way to receive health care services?
A consultation with a telehealth doctor will be similar to the care you receive from your physician when you call him or her for medical assistance when you are unable to get to their office.

Use Cigna Telehealth Connection to connect with a doctor about:

› General health
- Acne
- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Pink Eye
- Rashes
- Respiratory --Infections
- Sinus Infections
- Skin Infections
- Sore Throat
- Earaches
- Fever
- Headache
- Infections
- Insect Bites
- Joint Aches
- Nausea

How it works

Who can use telehealth services?
Employees and covered dependents enrolled in a medical plan through Cigna are eligible to use the program.

How do I access telehealth?
Covered employees and eligible dependents may access telehealth services from either **Amwell or MDLIVE**.
a. Through the web:
Amwell: Amwell for Cigna.com**
Phone: 855.667.9722
MDLIVE: MDLIVE for Cigna.com**
Phone: 888.726.3171
b. Download the **Amwell** for Cigna App and **MDLIVE** for Cigna App to your smartphone or mobile device.***
c. At myCigna.com
- Log in to **myCigna.com**
- Select the Cigna Telehealth Connection
- Select either **Amwell or MDLIVE**

What information do I need to provide to register for telehealth?
› First name
› Last name
› Gender
› Date of birth
› Cigna customer ID
You will be asked to create a user name and password. Once registered, you will receive an email confirmation. Each family member (employee/spouse or minor dependents) must create his or her own account.

Cigna Healthy Rewards® discounts[1]

Just Walk 10,000 Steps-A-Day walking program and fitness devices

8-week online program allows you to log your daily steps, track your progress and receive coaching tips and fun facts. Members receive pedometer and related materials ($29.95 + S&H) Option to extend online program by purchasing the 52-week step-up maintenance program.

Weight management discount programs
On-line, at home, telephone-based and traditional meeting options

Fitness club memberships

American Specialty Health Networks and ChooseHealthy provide access to over 12,300 fitness clubs, including Yoga and Pilates studios2

Complementary and alternative medicine
Reduced rates from over 32,5002 participating providers including acupuncturists, chiropractors, massage therapists, physical and occupational therapists, podiatrists and registered dieticians

Eyeglasses
Reduced rates at over 15,000 participating retailers and providers.3 Discounts on eyeglasses prescription sunglasses and vision exams.

Weight management discount programs On-line, at home, telephone-based and traditional meeting options

Health and wellness products
Choose Healthy Store offers discounts on vitamins and supplements, herbal products, dental products, homeopathic remedies, natural products, diet and sports nutrition, yoga and fitness activities, personal body care, books, audio, video and DVDs. Gaiam also offers yoga related products.

Laser Vision Correction (LASIK)
Reduced rates at over 600 participating facilities3

Hearing exams, aids and protection devices
Through Amplifon, save 40% on hearing exams and 20% on aids4. Enjoy a 60 day trial with a money back guarantee.
Screening is free and there is no charge for follow-up visits for the first year.

OPEN ACCESS PLUS IN-NETWORK

See how your health plan works for you.

With the Open Access Plus In-network plan, you get access to a large network of health care professionals and facilities. So, each time you need care, you choose the in- network doctor or facility that works best for you.

Enroll in the Open Access Plus In-network plan and get these options for care:

› Primary care physician (PCP) – You can decide to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended but not required.
› In-network – For your health care to be covered by the plan, you must choose a health care professional who is in the Cigna Open Access Plus network.
› No-referral specialist care – If you need to see a specialist, you don't need a referral to see an in-network doctor.
You may need precertification for hospital stays and some types of outpatient care. Use in-network health care professionals, and there's no paperwork to fill out.
› Out-of-network – If you choose to see a doctor who is not in the network, you will not have coverage except in emergencies.
› Emergency and urgent care – When you need care, you have coverage.

Predictable out-of-pocket costs – Depending on your plan, you may have to pay an annual amount (deductible) before the plan begins to pay for covered health care costs. Once you meet your deductible, you pay a copay or coinsurance (a portion of the charges) for most services from an in-network doctor or facility. Then, the plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100%.
24/7 service – Whenever you need us, customer service representatives will take your calls.
Partner with a health advocate – Even when you're not sure where to begin, you'll get confidential assistance from reliable, caring professionals who want to help you take an active role in your health.
Access to myCigna.com
› Learn more about your plan, and the coverage and programs that come with it.
› View claim history and account transactions; print claim forms.
› Find information and estimate costs for medical procedures and treatments.
› Compare hospitals by number of procedures performed, patients' average length of stay and cost.

Predictable out-of-pocket costs – Depending on your plan, you may have to pay an annual amount (deductible) before the plan begins to pay for covered health care costs. Once you meet your deductible, you pay a copay or coinsurance (a portion of the charges) for most services from an in-network doctor or facility. Then, the plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100%.
24/7 service – Whenever you need us, customer service representatives will take your calls.
Partner with a health advocate – Even when you're not sure where to begin, you'll get confidential assistance from reliable, caring professionals who want to help you take an active role in your health.
Access to myCigna.com
› Learn more about your plan, and the coverage and programs that come with it.
› View claim history and account transactions; print claim forms.
› Find information and estimate costs for medical procedures and treatments.
›Compare hospitals by number of procedures performed, patients' average length of stay and cost.

Who must get precertification?

Your doctor will help you decide which procedures require you to be admitted to the hospital and which can be handled on an outpatient basis. If your doctor is in the Cigna network, he or she will arrange for precertification. If you use an out-of-network doctor, you must make the arrangements. Remember, your care will not be covered. Look at your plan documents to see which procedures need precertification.

How do I find out if my doctor is in the Cigna network before I enroll?

It's quick and easy to search for in-network doctors, specialists, pharmacies, and hospitals close to home and work. Go to **Cigna.com** and click on "Find a Doctor." You can review the doctor's background, languages spoken and hospital affiliations, and get directions.

CIGNA SureFit

WE'RE HERE TO HELP

With Cigna SureFit, you get the Cigna One Guide service, our highly personalized, intelligent support that makes it easier to stay healthy and save money. Personal guides are available by phone and live chat online and through the myCigna® App.

During enrollment, we can help you:

› Understand your coverage options, plans and networks
› Identify the types of health plans available to you that best meet the needs of you and your family
› Find in-network doctors and choose a PCP

During enrollment, call 855.244.6216 (Monday through Friday, 8:00 am–midnight EST).

When your plan starts, we can help you:

› Understand your plan
› Find an in-network doctor, lab or urgent care center
› Change your PCP
› Connect to health coaches, pharmacies and more
› Stay on track with appointments and preventive care
› Get cost estimates to avoid surprises
› Get answers to questions about your health care bills

Find it all at myCigna

It's easy to manage your health and health care expenses 24/7/365 at **myCigna.com** or through the myCigna App.
› Chat live with a personal guide
› Review your coverage and access ID card information
› Choose doctors and facilities
› Estimate costs
› Manage prescriptions
› Access health resources
› Get directions to a doctor or facility (only available with app)

MEDICAL PLANS

The medical plans are arranged through **Cigna**

Benefits Network	Cigna Bronze	Cigna Silver	Cigna Gold	Cigna SureFit
Network Name	Open Access	Open Access	Open Access	SureFit
In Network Calendar Year Deductible	$4,000 Individual $8,000 Family	$3,000 Individual $6,000 Family	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family
In Network Out of Pocket Maximum	$6,500 Individual $13,000 Family	$6,350Individual $12,700 Family	$5,000 Individual $10,000 Family	$6,350 Individual $12,700 Family
Coinsurance	80% / 20%	80% / 20%	80% / 20%	80% / 20%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Referrals Required	No	No	No	Yes
PCP Required	No	No	No	Yes
Physician Office Visit	Deductible & Coinsurance	$25 copay	$25 copay	$20 copay
Specialist Office Visit	Deductible & Coinsurance	$45 copay	$50 copay	$55 copay
Diagnostic Lab	Deductible & Coinsurance	Plan pays 100%	Plan pays 100%	Plan pays 100%
Diagnostic X-rays	Deductible & Coinsurance	Plan pays 100%	Plan pays 100%	Plan pays 100%
Advanced Imaging (MRI, CT, PET Scans)	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	Deductible & Coinsurance	$250 copay	Deductible & Coinsurance	$300 Copay
Urgent Care	Deductible & Coinsurance	$50 copay	$65 Copay	$50 Copay
Outpatient Surgery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospitalization	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Out of Network Calendar Year Deductible	$8,000 Individual $16,000 Family	THIS PLAN DOES NOT HAVE OUT OF NETWORK BENEFITS	$5,000 Individual $10,000 Family	THIS PLAN DOES NOT HAVE OUT OF NETWORK BENEFITS
Coinsurance	50% / 50%		50% / 50%	
Out of Pocket Network Calendar Year Maximum	$13,000 Individual $26,000 Family		$10,000 Individual $20,000 Family	
PRESCRIPTION DRUGS				
Generics	**After Deductible $15**	**$15**	**$10**	**$15**
Preferred Brand	**After Deductible $45**	**$45**	**$30**	**$45**
Non-Preferred Brand	**After Deductible $65**	**$65**	**$50**	**$65**
Mail Order- Home Delivery (90-day supply)	**3x Retail Copays**	**3x Retail Copays**	**2x Retail Copays**	**3x Retail Copays**

Employee Deductions (24 Pay Periods)	Cigna Bronze	Cigna Silver	Cigna Gold	Cigna SureFit
Employee Only	**$14.80**	**$54.59**	**$65.21**	**$16.12**
Employee & Spouse	**$162.85**	**$218.39**	**$253.20**	**$186.36**
Employee & Child(ren)	**$126.38**	**$174.97**	**$207.65**	**$148.13**
Employee & Family	**$229.43**	**$307.50**	**$352.50**	**$298.36**

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HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

What is a "High Deductible Health Plan" (HDHP)?

• A high-deductible health plan (HDHP) is a health plan with lower monthly contributions and higher deductibles than a traditional PPO, HMO, or other Plan
• All eligible expenses apply to the deductible and co-insurance; there are no copays for office visits, emergency room or prescription drugs
• If you enroll in the high-deductible health plan, you are eligible for a Health Savings Account (HSA)

Every employee that enrolls in the HDHP will receive a Health Savings Account

- A Health Savings account is a tax-free medical savings account
- HSA Funds can be used to pay for qualified medical, dental, and vision expenses now and in retirement (e.g., Medicare premiums)
- Unused account balance rolls over year after year, and continues to earn interest taxfree. There is no "USE IT OR LOSE IT" rule
- The Health Savings Account is portable and belongs to you, similar to a 403(b) plan
- Annual Tax-free contribution limits are adjusted annually; in 2019 the individual limit is$3,500 and the family limit is $7,000. Couples and single parents fall under the family limit.
- If you are over age 55, you can make an additional contribution of $1,000 per year

Contributions to your HSA

- **Employee Contributions to the HSA are Optional**
  - You can elect additional pre-tax contributions through payroll or change payroll deductions at any time
  - You can make additional post-tax contributions online or by check

HEALTH SAVINGS ACCOUNT (HSA)

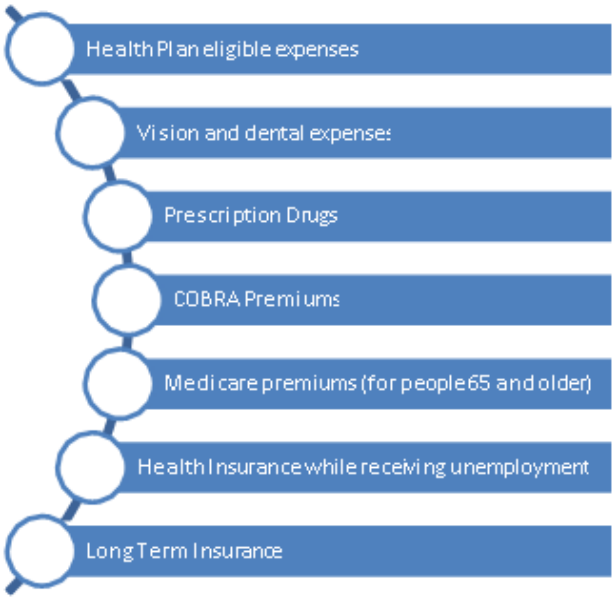
The HSA benefits are arranged through HSA Bank

Employee contributions HSA Qualified medical expenses

Using the HSA

- Payments can be made with a convenient debit card drawing from the HSA Account
- HSA funds must be in the account before you can access them. In the event the fund balance does not cover the expense at the time of service, you can pay for the service and later reimburse yourself
- You can take advantage of long-term investment options once the account reaches a balance of $2,000
- HSA contributions are deducted pre-tax, funds are withdrawn tax free, and fund interest and investment earnings are also tax-free

Examples of Qualified Medical Expenses



- Acupuncture
- Cancer Screenings
- Chiropractor
- Crutches, Walkers, Wheelchairs (DME)
- Deductibles, Copays, Coinsurance
- Diabetic Supplies
- First Aid Kits
- Flu Shots
- Hearing aids
- Immunizations
- Laser eye surgery, Lasik
- Lodging at a hospital
- Medical supplies
- Physical, Speech, Occupational Therapy
- Orthodontia
- Radiology
- Stop-smoking programs
- Surgery (non-cosmetic)
- And more….

For a complete list of qualified medical expenses:
Visit the IRS website at **https://www.irs.gov/publications/p969#en_US_2017_publink1000203083**

To contribute to the HSA the following criteria must be met

- You must be enrolled in a qualified High Deductible Health plan (HDHP), such as the one the Health Plan is offering
- You cannot have other health coverage (see IRS Publication 969)
- You (or your spouse, if a tax dependent) cannot be enrolled in any part of Medicare or Medicaid
- Medicare eligible employees cannot contribute to the HSA fund, but can continue to draw from the account
- You cannot be listed as a dependent on someone else's tax return
- You cannot be active in the military
  Veterans enrolled in a HDHP with no other disqualifying coverage and who have a service-connected disability may make or receive HSA contributions regardless of when they received VA benefits
- You cannot be enrolled in a full purpose Health FSA through a spouse's plan

HEALTH SAVINGS ACCOUNT (HSA) OVERVIEW

GETTING STARTED WITH YOUR HSA

Cigna. Together, all the way.®

hsabank own your health. A Division of Webster Bank, N.A. Member FDIC

Access your account online to view current balance information, set up or update your profile, designate a beneficiary, view online statements, or manage your healthcare expenses. Simply log on to myCigna.com or download the myCigna mobile app[1] . From myCigna, click on "Visit your HSA bank to manage your account", to link to the HSA Bank Customer Website.

You can designate an authorized signer at any time on the Member Website by simply navigating to the Profile tab, then clicking on "Add Authorized Signer[2]." By designating an authorized signer on your account, you authorize the designee as "Authorized Signer" to transact business with and give instructions to HSA Bank regarding your HSA.

Monitor your account! We encourage you to elect to receive statements, tax documents, notifications, and alerts electronically. The Statements & Notifications page on the Member Website outlines all the documents and notifications available. It is your responsibility to regularly review your account, and to contact us immediately if you notice any discrepancies in your account activity.

EASY WAYS TO USE YOUR HSA

1. **Maximize your contributions:** The more you contribute, the harder your HSA can work to save on taxes, reduce your healthcare costs and build savings for the future. It's to your advantage to contribute as much as you can, up to the annual maximum IRS limits. You can contribute to your HSA through a payroll deduction, online transfer, or personal check.

2. **Use your HSA funds:** You can pay for IRS-qualified medical expenses with funds from your HSA by using your debit card. You can also order checks (fees[3] may apply) to pay for these expenses, or you can pay for part or all of them out-of-pocket and reimburse yourself via check or online transfer of funds. You cannot use funds from your HSA to pay for IRS-qualified medical expenses that occurred before the account was opened.

3. **Self-directed Investments:** You will have the opportunity to invest HSA funds in self-directed investment options. To be eligible to open a self-directed investment account you typically need to accumulate $2,000 in your HSA. Visit the Member Website to learn more.

GAP PLAN

The Gap plans are arranged through CWI – CHUBB

Your Benefits (Only for those enrolled in the HDHP)

Benefit Period Deductible	**$1,500** per Benefit Period (Per Covered Person) **$3,000** per Benefit Period (Per Family)
Supplemental Medical Coinsurance	**100%** Supplemental Medical Coinsurance means the maximum percentage that We will pay under this Policy for Covered Expenses incurred by a Covered Person.
Combined Hospital Expense Benefit and Outpatient Benefit (Includes Ambulance Transportation)	**$5,000** per Benefit Period (Maximum Benefit Per Covered Person) **$10,000** per Benefit Period (Maximum Benefit Per Family)

Benefits & Features

Hospital Expense Benefit

We will pay up to the Total Maximum Benefit per Benefit Period as stated in the Schedule of Benefits if a Covered Person is Hospital Confined as a direct result of an Injury sustained in a Covered Accident or Sickness and the expenses are covered by the Insured's Major Medical Plan. Hospital Confinement must begin after the Policy Effective Date.

All Hospital Expense Benefits are limited to out-of-pocket expenses incurred by the Covered Person, including:

a. The Deductible the Covered Person is required to pay under the Insured's Major Medical Plan.
b. The Coinsurance amount the Covered Person is required to pay under the Insured's Major Medical Plan.

This benefit provision is in lieu of all other benefits payable under the Policy. All benefits are paid on the basis of the expenses actually incurred.

Outpatient Benefit

We will pay up to the Maximum Benefit shown in the Schedule of Benefits for Outpatient treatment of an Injury sustained in a Covered Accident or Sickness. Benefits are limited to the difference between the amount paid by the Insured's Major Medical Plan and the actual Covered Expenses incurred, including any out-of-pocket expenses such as Deductibles and Coinsurance. These services will be covered only to the extent that they are provided by, or under the supervision of, a Doctor at a Doctor's Office or a Hospital, outpatient surgical facility, Hospital emergency room, diagnostic testing facility or similar facility that is licensed to provide outpatient treatment. Benefits are not payable under this Outpatient Benefit for any expenses incurred for an examination by a Doctor in a Doctor's Office.

Ambulance – Included in Outpatient Benefit

Benefits are payable for Covered Expenses if a Covered Person requires ambulance transportation to a Hospital for an Injury or Sickness, and the Covered Person is not Hospital Confined within 48 hours of being transported to the Hospital. Covered Expenses for ambulance transportation are subject to the Outpatient Maximum Benefit per Benefit Period shown in the Schedule of Benefits. This benefit is in addition to any Hospital Expense Benefits.

Employer Paid

How do I file a claim for my GAP plan?

You have two options to file a GAP claim with CWIBenefits:

1. Present Your ID Card to the Provider

The easiest is when you go to see a medical provider, be sure to not only supply them with your medical ID card but also your CWI GAP ID card. That way, your provider can file your claim to the medical insurance and then once they receive the primary explanation of benefits (EOB), they can file the claim with CWI using the instructions provided on your CWI GAP ID card.

2. Submit a Claim Form from your Member Portal If for any reason a provider cannot submit the claim for you, then you can:

a. Logon to the member portal at www.cwibenefitsl.com/member
b. Download a claim form under the "Documents" tab
c. Follow the instructions and fully complete the claims form
d. And submit to CWI for processing

If you have any questions, feel free to call the CWI Customer Service line at 855-294-2489.

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GAP PLAN

The Gap plans are arranged through CWI – CHUBB

Your Benefits (For Those not enrolled in the HDHP)

Benefit Period Deductible	No Deductible
Supplemental Medical Coinsurance	**100%** Supplemental Medical Coinsurance means the maximum percentage that We will pay under this Policy for Covered Expenses incurred by a Covered Person.
Combined Hospital Expense Benefit and Outpatient Benefit (Includes Ambulance Transportation)	**$3,000** per Benefit Period (Maximum Benefit Per Covered Person) **$6,000** per Benefit Period (Maximum Benefit Per Family)

Benefits & Features

Hospital Expense Benefit

We will pay up to the Total Maximum Benefit per Benefit Period as stated in the Schedule of Benefits if a Covered Person is Hospital Confined as a direct result of an Injury sustained in a Covered Accident or Sickness and the expenses are covered by the Insured's Major Medical Plan. Hospital Confinement must begin after the Policy Effective Date.

All Hospital Expense Benefits are limited to out-of-pocket expenses incurred by the Covered Person, including:

a. The Deductible the Covered Person is required to pay under the Insured's Major Medical Plan.
b. The Coinsurance amount the Covered Person is required to pay under the Insured's Major Medical Plan.

This benefit provision is in lieu of all other benefits payable under the Policy. All benefits are paid on the basis of the expenses actually incurred.

Outpatient Benefit

We will pay up to the Maximum Benefit shown in the Schedule of Benefits for Outpatient treatment of an Injury sustained in a Covered Accident or Sickness. Benefits are limited to the difference between the amount paid by the Insured's Major Medical Plan and the actual Covered Expenses incurred, including any out-of-pocket expenses such as Deductibles and Coinsurance. These services will be covered only to the extent that they are provided by, or under the supervision of, a Doctor at a Doctor's Office or a Hospital, outpatient surgical facility, Hospital emergency room, diagnostic testing facility or similar facility that is licensed to provide outpatient treatment. Benefits are not payable under this Outpatient Benefit for any expenses incurred for an examination by a Doctor in a Doctor's Office.

Ambulance – Included in Outpatient Benefit

Benefits are payable for Covered Expenses if a Covered Person requires ambulance transportation to a Hospital for an Injury or Sickness, and the Covered Person is not Hospital Confined within 48 hours of being transported to the Hospital. Covered Expenses for ambulance transportation are subject to the Outpatient Maximum Benefit per Benefit Period shown in the Schedule of Benefits.
This benefit is in addition to any Hospital Expense Benefits.

Employee Deductions (24 Pay Periods)	Age 18-54	Age 55+
Employee Only	$31.61	$67.08
Employee & Spouse	$56.10	$110.68
Employee & Child(ren)	$64.79	$100.62
Employee & Family	$89.29	$144.22

DENTAL PLAN

The dental plans are arranged through **Cigna**

- Unlimited Annual Maximum
- No Deductible
- No Waiting Periods
- No Claim Forms to submit
- Pediatric Dentist for your child under the age of 13

When you enroll in the **DHMO plan** you will select a network general dentist who will handle your dental care needs. You will receive a Patient Charge Schedule that lists the specific procedures covered by the plan and the amount you would pay your dentist (copays).

CIGNA DENTAL CARE (DHMO) (P6XVO) – Patient Charge Schedule		
ADA Code	**Procedure Description**	**Patient Charge**
	Office Visit Fee	**$5.00**
D0120	Periodic oral evaluation Established patient	**$0.00**
D0210	X-rays Intraoral Complete series of radiographic images (limit 1 every 3 years)	**$0.00**
D0274	X-Rays (bitewings) Single, 2, 3, 4 radiographic images	**$0.00**
D1351	Sealant Per tooth	**$11.00**
D1110	Prophylaxis (cleaning) Adult (limit 2 per calendar year)	**$0.00**
D1515	Space Maintainer Fixed Bilateral	**$30.00**
D2140	Amalgam 1 surface, primary or permanent	**$0.00**
D2940	Protective restoration	**$6.00**
D7220	Removal of impacted Soft tissue	**$55.00**
D4210	Gingivectomy (4 or more teeth per quadrant)	**$145.00**
D2644	Onlay Porcelain / ceramic, 4 or more surfaces	**$215.00**
D2722	Crown Resin with noble metal	**$220.00**
D8670	Comprehensive orthodontic treatment adolescent (up to age 19)	**$1,464**
D8670	Comprehensive orthodontic treatment adult	**$2,160**

Primary Care Dentist must be selected

Participants will receive a personalized ID card

DEPENDENT ENROLLMENT AGE LIMITATION To 30

Employer Paid Benefit

DENTAL PLAN

The dental plans are arranged through **Cigna**

Our **PPO** dental plans allows you to seek services from any licensed dentist, but you will receive higher benefits and lower Out-of-Pocket costs when obtaining care from a preferred dental care provider

Plan Design	TOTAL CIGNA DPPO		
	Cigna DPPO Advantage	Cigna DPPO	Out-of-Network
Calendar Year Deductible			
Individual / Family	$100 / $300	$150 / $450	$150 / $450
Preventative Services			
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Emergency Care to Relieve Pain	100%	90%	90%
Basic Services			
Anesthesia Fillings Minor and Major Periodontics Repairs, Crowns, Bridges & Inlays Repairs Dentures Root Canal Therapy / Endodontics Scaling & Root Planning (per quadrant) Oral Surgery Simple Extractions Oral Surgery All Except Simple Extractions	80%, After Deductible	70%, After Deductible	70%, After Deductible
Major Services			
Bridges and Dentures Inlays, Onlays, Crowns Stainless Steel Resin Crowns	50%, After Deductible	40%, After Deductible	40%, After Deductible
Calendar Year Maximum			
In-Network	$2,000	$1,500	$1,500
Orthodontia (Dependent children to age 19) Lifetime Maximum	50% $1,000	50% $1,000	50% $1,000

Employee Deductions (24 Pay Periods)	DPPO
Employee Only	**$16.89**
Employee & Spouse	**$36.65**
Employee & Child(ren)	**$33.89**
Employee & Family	**$44.03**

DEPENDENT ENROLLMENT AGE LIMITATION TO 30

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VISION PLAN

The vision plan is arranged through **Cigna**

Cigna Vision			
Schedule of Vision Coverage			
Coverage	**In-Network**	**Out-of-Network**	**Frequency Period**
Exam Copay	$10	N/A	12 months
Exam Allowance	Covered 100% after copay	Up to $45	12 months
Materials Copay	$20	N/A	12 months
Eyeglass Lenses Allowances: Single Vision Lined Bifocal Lined Trifocal Lenticular	 Covered 100% after copay Covered 100% after copay Covered 100% after copay Covered 100% after copay	 Up to $32 Up to $55 Up to $65 Up to $80	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: Elective Therapeutic	 Up to $110 Covered 100%	 Up to $98 Up to $210	 12 months 12 months
Frame Retail Allowance	Up to $130	Up to $71	24 months

In-Network Coverage Includes***

- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions
  - Polycarbonate lenses for children under 19 years of age
  - Oversize lenses
  - Minimum 20% savings on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles.
  - Progressive lenses covered up to bifocal lens amount with 20% savings on the difference.
  - One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings amount that exceeds frame allowance;
  - One pair of contact lenses or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit, may not receive contact lenses and frames in same benefit year.

Employee Deductions (24 Pay Periods)	Vision
Employee Only	**$4.13**
Employee & Spouse	**$7.44**
Employee & Child(ren)	**$7.87**
Employee & Family	**$12.42**

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BASIC LIFE and ACCIDENTAL DEATH & DISMEMBERMENT

St. Thomas University provides basic life and accidental death & dismemberment (AD&D) insurance which provide to you and your beneficiaries important financial protection if you are injured or die while covered under the plan. This policy is administered through Cigna. Employees are covered for a benefit of 1 time their annual salary, maximum $50,000.

VOLUNTARY LIFE / ACCIDENT DEATH & DISMEMBERMENT

In addition to Basic Life Insurance, you may also purchase Voluntary Life Insurance for yourself, your spouse and your dependent children. However, you may only elect coverage for your dependents if you enroll and are approved for Voluntary Life coverage for yourself.

Employee, you can select life insurance coverage in units of $50,000

Guaranteed Issue Amount: the greater of a or b:
a) the lesser of 4 times annual salary or $350,000, or
b) $1,000,000 when combined with the Basic Guaranteed Issue Amount

Maximum Benefit: $1,000,000, when combined with the Basic Maximum Benefit Amount

The Guaranteed Issue Amount will be rounded to the next higher $50,000, if not already a multiple thereof.

Spouse: You may choose one of the following options for your spouse.

- $12,500
- $25,000
- $50,000

*Spouse maximum cannot exceed 100% of your coverage amount. The guaranteed coverage amount for your spouse is $50,000.

Your unmarried, dependent children: Units of $2,000 to a maximum of $10,000. The guaranteed coverage amount for your children is $10,000. The maximum benefit for children under six months of age is $500.

Age Based Reductions

65% of the Life Insurance Benefit at age 70
50% of the Life Insurance Benefit at age 75

Voluntary Life / AD&D Age Band Monthly Rate per $1,000	Employee Voluntary Life / AD&D	Spouse Voluntary Life
15-29	$0.086	$0.09
30-34	$0.086	$0.09
35-39	$0.126	$0.14
40-44	$0.292	$0.23
45-49	$0.256	$0.34
50-54	$0.446	$0.60
55-59	$0.706	$0.97
60-64	$1.552	$1.17
65-69*	$1.406	$1.97
70+	$5.172	$5.31

Life Assistance Program

Life. Just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, your Life Assistance & Work/Life Support Program is there for you. It can help you and your family find solutions and restore your peace of mind.

Call us anytime, any day.
We're just a phone call away whenever you need us. At no extra cost to you. An advocate can help you assess your needs and develop a solution. He or she can also direct you to community resources and online tools.

Visit a specialist.
You have face-to-face sessions with a behavioral counselor available to you - and your household members. Call us to request a referral.

Monthly Webinars
Educational seminars on a variety of relevant topics such as managing your life, work, money and health, are available in a quarterly calendar of monthly webcasts distributed to your employer.

Achieve work/life balance.
For help handling life's challenges go on line for articles and resources including on family, care giving, pet care, aging, grief, balancing, working smarter, and more.

Legal consultation and referrals*
Receive a free 30-minute consultation with a network attorney. And up to a 25% discount on select fees.

Financial consultations.
Receive a free 30-minute consultation and 25% discount on tax planning and preparation.

Life Assistance Program – 24/7 support

Phone: **800.538.3543**
website: **www.cignalap.com**

Cigna Secure Travel

Cigna Group Insurance®

ADDITIONAL PROTECTION WHEN YOU TRAVEL

Emergencies can happen while traveling, but help is only a phone call away with Cigna Secure Travel.

Cigna Secure Travel. o0ers pre-trip planning, assistance while traveling and emergency medical transportation benefits for covered persons traveling 100 miles or more from home (see your plan for details). Service is a phone call away, 24/7/365 – in an emergency you can even call collect.

PRE-TRIP PLANNING	TRAVELING ASSISTANCE	EMERGENCY ASSISTANCE*
• Immunization requirements • Visa and passport requirements • Embassy/consular referrals Foreign exchange rates • Travel advisories and weather conditions • Cultural information	• 24-hour multilingual assistance and referral to interpretation and translation services • Referrals to physicians, dentists, medical facilities and legal assistance providers • Arrangements for payment of medical expenses up to $10,000 if required prior to treatment** • Assistance with lost or stolen items, including luggage and prescription replacement services** • Emergency cash advances, up to $1,500** • Advancement of bail**	• Emergency evacuation and repatriation, when medically necessary; arrange and cover the cost of transportation to the nearest adequate medical facility*** • Travel arrangements for the return of a travel companion or children under age 18 who are left unattended due to the covered person's medical emergency • Cover round-trip transportation as well as accommodations, up to $150 per day for up to seven days, for a family member or friend to visit a covered person who is hospitalized more than 100 miles away from home for more than seven days • Arrange and cover the costs associated with returning a deceased covered person's remains to his or her place of residence for burial • Emergency message relay, toll-free • Assistance with making emergency travel arrangements**

Cigna Secure Travel

From the United States and Canada, call 888.226.4567
From other locations, call collect 202.331.7635
Fax: 202.331.1528 Email: Cigna@gga-usa.com
Emergency services must be coordinated through Cigna Secure Travel®. Services coordinated outside of this program may not be eligible for payment.
Policyholder name: _____
Policy # _____ Group# 57

To learn more call 888.226.4567

Emergency Assistance services may be insured under a group or blanket insurance policy issued by Life Insurance Company of North America or Cigna Life Insurance Company of New York. All other Cigna Secure Travel services are NOT insurance and do not provide reimbursement of expenses or financial losses. Expenses for medical care are not covered.
** Covered person is responsible for any advances, payments, travel-related or replacement
costs and must provide confirmation of reimbursement. Credit card(s) used to guarantee reimbursement must have sufficient available limit to cover the amount of the advance.
*** Initial transport by ambulance following a covered medical emergency is excluded.

Together, all the way.®

Cigna.

VOLUNTARY SHORT-TERM DISABILITY

The Voluntary STD plan is administered through **Cigna**

VOLUNTARY SHORT-TERM DISABILITY	
Weekly Benefit	66.7% of covered weekly salary
Weekly Benefit Maximum	$1,500
Benefit Waiting Period	Day 7
Maximum Duration	13 Weeks

LONG TERM DISABILITY (LTD)

The LTD plan is administered through **Cigna, an employer paid benefit.**

Long- Term Disability (LTD) benefits are provided by St. Thomas University to all eligible employees at no cost. Long-Term Disability benefits replace up to 60% of your base pay, up to a maximum of $6,000 per month. LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive.

LONG TERM DISABILITY	
Monthly Benefit	60% of covered monthly salary
Monthly Benefit Maximum	$6,000
Benefit Waiting Period	Day 90
Maximum Duration	Up to age 65 or Social Security Normal Retirement Age (SSNRA)

FLEXIBLE SPENDING ACCOUNT (FSA)

Additional Features of our benefit plan

Within 30 days of your date of hire, you have the option to establish a dependent care and/or health care spending account.
You can contribute up to $5,000 pre-tax for a dependent care reimbursement account and/or up to $2,750 pre-tax per plan year for reimbursement of health care expenses that would otherwise be "out-of-pocket" expenditures. Please note that any amounts left in the dependent care reimbursement account at the end of the plan year are forfeited. The Plan shall provide for a carryover of up to $500 of any amount remaining unused in a health flexible spending account as of the end of the plan year. Such carryover may be used to pay or reimburse medical expenses under the health FSA incurred during the entire plan year to which it is carried over. Once your elections are made they cannot be changed unless you have a qualifying family event.

403(b) Retirement Options

All full-time regular employees and part-time employees scheduled to work 20 or more hours per week may begin participation in our retirement savings plan on the first of the month following 30 days of employment with the University. We offer you the option of selecting between two providers: TIAA or VALIC. There is a one year waiting period to receive the University's 4% contribution of annual base salary provided the employee makes a minimum contribution of 4% through payroll deductions.

Benefits	**Healthcare FSA** (debit card available)
Account Ownership	Employer
Qualified Medical Expenses*	Medical, Dental and Vision
Maximum Annual Contribution	$2,750
Rollover	Up to $500 maximum
Dependent Care Account	$5,000

PREFERRED LEGAL PLAN™

Legal Services

The Preferred Legal Plan™ (PLP) is a licensed legal expense organization providing its members with legal advice and discounted fee representation on all types of legal services including:

Traffice Tickets
Divorce
Real Estate
Wills
Probate
Bankruptcy
Immigration
Credit Report Issues
Child Custody & Support
Criminal Defense
Civil Litigation
Personal Injury
Landlord Tenant Disputes
Domestic Violence

Unlimited free legal advice via phone consultation
Free review of legal documents
Free face-to-face initial consultations with attorneys
Free letters and phone calls on members' behalf
Free credit report analysis and repair and settling accounts in collection
Free simple wills for member and spouse
Free notary services

No long-term contracts are required and members can cancel at any time. Membership is portable if you are no longer a St. Thomas University employee, and includes unlimited use of services.

Employee Deductions (24 Pay Periods)	
Employee / Employee & Spouse	**$4.98**

Identity Works - A Part of ExperianSM

Indentity Works is pleased to partner with Preferred Legal PlanTM. Indentity Works provides more than identity protection. We provide peace of mind. As a part of Experian, a leader in credit services and decision analytics, we use world-class security and technology standards. When it comes to identity protection, no one else has the backing of Experian. And no one else comes close.

Comprehensive Features to Fight Identity Theft

Early Warning Surveillance Alert™ notifications via email or text inform members of new activity related to their identities through daily monitoring. Daily 3-Bureau Credit Monitoring tracks 50 leading indicators of identity theft Internet Scan monitors online sources where personal data is sold Change of Address Monitoring reported by USPS NCOA and credit bureau Lost Wallet Protection with monthly email notifications of "all clear" or other status $1,000,000 Identity Theft Insurance to cover items like illegal electronic fund transfers, lost wages, legal fees and private investigator costs Identity Theft Resolution Agents help resolve potential identity theft from start to finish. With a highly trained, dedicated agent, members aren't left on their own to contact creditors, close fraudulent accounts, place fraud alerts on their Experian credit reports and more. A Complete Personal Experian Credit Report so members can check for inaccurate information that may be a sign of past identity theft Additional Resources so consumers can learn more about identity protection.

Employee Deductions (24 Pay Periods)	
Employee Only	**$4.50**
Employee & Spouse	**$9.00**

LegalShield and IDShield Legal Benefits

Have You Ever?

- Needed your Will prepared or updated
- Been overcharged for a repair or paid an unfair bill
- Had trouble with a warranty or defective product
- Signed a contract
- Received a moving traffic violation
- Had concerns regarding child support
- Worried about being a victim of identity theft
- Been concerned about your child's identity
- Lost your wallet
- Worried about entering personal information online
- Feared the security of your medical information
- Been pursued by a collection agency

What is LegalShield?

LegalShield was founded in 1972, with the mission to make equal justice under law a reality for all North Americans. The 3.5 million individuals enrolled as LegalShield members throughout the United States and Canada can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs. LegalShield has provided identity theft protection since 2003 with Kroll Advisory Solutions, the world's leading company in ID Theft consulting and restoration. We have safeguarded over 1 million members, provided more than 200,000 identity consultations, and helped restore nearly 10,000 individual identities.

The LegalShield® Membership Includes:

- Legal Advice – personal and business legal issues
- Letters/calls made on your behalf
- Contracts & documents reviewed (up to 10 pages)
- Residential Loan Document Assistance
- Attorneys prepare your Will, your Living Will and your
- Health Care Power of Attorney
- Moving Traffic Violations (available 15 days after enrollment)
- Trial Defense including Pre-Trial & Trial
- IRS Audit Assistance
- 25% Preferred Member Discount (Bankruptcy, Criminal
- Charges, Other Matters, etc.)
- Member App for easy access
- 24/7 Emergency Access for covered situations

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under age 18 for whom the member is legal guardian; never married, dependent children up to age 26 if a full-time college student; and physically or mentally disabled dependent children.

Full Service Restoration
Complete identity recovery services by Kroll Licensed Private Investigators and our $5 million service guarantee ensure that if your identity is stolen, it will be restored to its pre-theft status.

Privacy Monitoring
Monitoring your name, SSN, date of birth, email address (up to 10), phone numbers (up to 10), driver license & passport numbers, medical ID numbers (up to 10), payday loans, and change of address verification provides you with comprehensive identity protection service that leaves nothing to chance.

Security Monitoring
SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle.

Consultation
Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection

IDShield plans are available to an individual or family. A family rate covers member, member's spouse, up to 8 dependents up to 18.

Contact: Harold Kidd 210-860-9274
Based on 24 Pay Periods

Employee Deductions (24 Pay Periods)	
Employee Only	**$8.48**
Employee & Spouse	**$11.98**

This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

Tuition Benefit

Tuition Benefit & Tuition Exchanges
St. Thomas University's tuition benefit program is available immediately after the start of employment for regular (non-temporary) full-time faculty and staff and for part-time seasonal coaches (subject to limitations outlined in the Employee Handbook.

Undergraduate tuition: All regular (non-temporary) full-time faculty and staff, their spouse and eligible dependent children, and all part-time seasonal coaches (not to include dependent spouses or children) are eligible for an unlimited number of credits per year.

Graduate tuition for regular full-time employees: Available to all regular (non-temporary) full-time faculty and staff, their spouse and eligible dependent children, and subject to taxation (see below) for an unlimited number of credits per year.

Graduate tuition for part-time seasonal coaches: Seasonal part-time coaches are eligible to take graduate courses under the tuition benefit as follows:

Fall: 6 credits
Summer: 3 credits
Spring: 6 credits

Graduate tuition taxation: Employees are taxed for graduate-level tuition after the cost of tuition exceeds $5,250 in a calendar year. Graduate tuition for eligible for eligible dependents is fully taxable to the employee. Questions on graduate taxation should be directed to the Office of Human Resources.

Doctoral Programs
A 40% discount will be given to full-time eligible employees of STU for courses taken towards the Ed.D. degree offered through the Department of Professional Studies and for the Ph.D. degree in Practical Theology. The discount for the doctoral programs does not apply to seasonal part-time coaches or employee dependents. Eligible employees who opt for the 40% discount towards the Ph.D. degree in Practical Theology will not be eligible to receive any other scholarships.

Application Procedure: To apply for tuition benefit for yourself, your spouse or dependent children, complete the Faculty/Staff Application of Tuition Benefit Form available in the Office of Human Resources and submit to the Registrar's Office (for employees) or Student Success Center (for dependents).

Tuition Exchange Program
We are members of The Tuition Exchange, Inc. and CIC-TEP (offered through the Council of Independent Colleges). For information on participating institutions, please visit www.tuitionexchange.org or www.cic.edu (click on "Member Services" and "Tuition Exchange Program").

These organization provide a national scholarship exchange program for dependent children of full-time faculty and staff from among their member institutions.

Scholarships are awarded by the importing institution. Employees interested in learning about participating institutions and applications and application deadlines are encouraged to visit the websites and contact the STU Tuition Exchange Liaison Officer, Lenore Prado, Associate Director of Human Resources, for additional information.

DISCOUNT MARKET PLACE

Welcome to St. Thomas University Discount Marketplace!

Enjoy discounts, rewards and perks on thousands of the brands you love in a variety of categories:

- Travel
- Auto
- Electronics
- Apparel
- Local Deals
- Education
- Entertainment
- Restaurants
- Health and Wellness
- Beauty and Spa
- Tickets
- Sports & Outdoors

Hertz · CityPASS · SixFlags · amc · Hotels · GROUPON · Budget · DELL · employee AUTO BUYING powered by TRUECar · HOME CHEF · Sam's Club · Nutrisystem · Office DEPOT OfficeMax · Lenovo · AVIS · LEGOLAND · hp · jiffy lube

It's easy to access and start saving!

1. Go to stu.benefithub.com
2. Enter your email address on "Create an Account"
3. Enter your information and click on "Create Your Profile >"

Directory

Coverage / Administrator	Group Number	Phone Number	URL
Medical / Rx / Cigna	00628720	1-866-494-2111	www.mycigna.com
Life Insurance / Cigna	966676	1-800-362-4462	www.mycigna.com
Disability / Cigna	960869	1-800-362-4462	www.mycigna.com
Dental / Cigna	0628720	1-800-244-6224	www.mycigna.com
Vision / Cigna	0628720	1-877-478-7557	www.mycigna.com
Telehealth / Amwell	N/A	1-855-667-9722	www.mycigna.com
Telehealth / MDLive	N/A	1-888-726-3171	www.mycigna.com
Specialty Pharmacy / Accredo	N/A	1-877-826-7657	www.Accredo.com
Medical GAP / CHUBB – CWI	66030485	1-855-294-2489	www.chubb.com
Health Savings Account / HSA Bank	N/A	1-866-494-2111	www.hsabank.com
Legal Services / Preferred Legal	N/A	1-888-577-3476	www.preferredlegal.com
Legal Shield	N/A	1-800-654-7757	www.legalshield.com
Human Resources	Bettina Romanat	305-628-6514	bromanat@stu.edu

Brown & Brown of Homestead
Your Dedicated Employee Benefits Insurance Consultant

Aida Rubio, HIA
Account Executive

- Direct Line: (305)246-7542 / arubio@bbinsfl.com

Jeanette Beihswingert
Account Coordinator

- Direct Line: (305) 246-7516 / jbeihswingert@bbinsfl.com

Evelyn R. Alvarez
Executive VP & Managing Director,
Employee Benefits

- Direct Line: (305) 246-7541 / ealvarez@bbinsfl.com

This guide describes the benefit plans available to you as an employee of St. Thomas University. The details of these plans are contained in the official Plan Documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all the details that are included in your Summary Plan Description (SPD).

This booklet contains an overview of the valuable benefits package available to you at St. Thomas University. While every effort has been made to ensure that this booklet accurately reflects the provisions of the plans, only the official plan documents govern the operation of the plans and payments of benefits.

If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the Plan Documents, the formal wording in the Plan Documents will govern.

The information in this guide should in no way be constructed as a promise or guarantee of employment or benefit coverage. Pricing, underwriting, plan specifics, and all other product features are at the discretion of the Insurance Company. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents.

St. Thomas University has retained the services of Brown & Brown of Florida Inc., Employee Benefits Homestead Division to assist its employees with the benefits outlined in this booklet. This benefit guide was created by Brown & Brown of Homestead for the exclusive use of the St. Thomas University and its employees. It is not intended to be copied or distributed without their consent and approval.