ABILENE CHRISTIAN UNIVERSITY

2013 **Benefit Enrollment Guide**

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Quick Reference Guide

TOPIC	VENDOR	PHONE AND WEBSITE
ACU Benefits Help Line	Gallagher Benefit Services	1.866.99.HRTLC (47852) fax 713.358.7841 acuhelpline@ajg.com or x3359 from on-campus
ACU Benefits Website	Gallagher Benefit Services	www.mybensite.com/acu
Medical	Blue Cross Blue Shield of Texas (BCBSTX) Group #068773	1.800.521.2227 www.bcbstx.com
Prescription Drugs— Retail	Prime Therapeutics	1.800.521.2227 www.myrxhealth.com
Prescription Drugs— Mail-Order	Prime Therapeutics	1.800.521.2227 www.myrxhealth.com
Prescription Drugs— Specialty	Triessent Specialty Pharmacy	ph 1.888.216.6710 fax 1.866.203.6010
Dental	Blue Cross Blue Shield of Texas (BCBSTX) Group #107361	1.800.521.2227 www.bcbstx.com
Vision	Vision Service Plan (VSP) Group #1109154	1.800.852.7600 www.vsp.com
Flexible Spending Accounts Healthcare/Dependent Care	Discovery Benefits	1.866.451.3399 www.discoverybenefits.com
Life and AD&D	Unum Life/ AD&D Group #115658-001 STD Group #115657-001 LTD Group #115658-002	1.800.421.0344 www.unum.com
Disability and Leave of Absence	Unum	1.866.779.1054
Long-Term Care	Unum	1.800.227.4165 Policy #511830 www.unum.com
Employee Assistance Program	Unum	1.800.854.1446 www.lifebalance.net
Retirement	TIAA-CREF	1.800.842.2733 www.tiaa.cref.org/acu
Identity Theft	AIG Group #7077631	1.866.IDHELP2 (434.3572)
Travel Assistance	Assist America, Inc.	Within U.S.: 1.800.872.1414 Outside U.S.: + 609.986.1234 Email: medservices@assistamerica.com Website: unum.com/travelassistance

Table of Contents

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage, which started in 2006. Please see page 29 for more details.

The Fine Print

The information contained in this summary should in no way be construed as a promise or guarantee of employment or benefits. ACU reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this guide and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents available from Human Resources.

This Benefits Enrollment Guide highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act (ERISA) as a Summary of Material Modifications and should be kept with your most recent Summary Plan Description.

Membership Guidelines

Which ACU employees and dependents are eligible for coverage?

Employees: Full-time and reduced full-time staff and faculty are eligible for benefits. Half-time employees are eligible for all benefits except for health and prescription coverage. Part-time employees do not qualify for benefits. Full-time and half-time employees become eligible for applicable benefits coverage on their date of hire.

Dependents: Dependents eligible for benefits include your spouse as defined under the Federal Defense of Marriage Act and your dependent child(ren). Dependent child(ren) include:

- Natural children
- Legally adopted children or children placed for adoption for whom legal adoption proceedings have been started
- Stepchildren
- Children for whom benefits must be provided through a Qualified Medical Child-Support Order
- Any other child for whom you have obtained legal guardianship

Children are eligible for medical, dental, life and vision coverage from birth up to age 26. If a child becomes mentally or physically disabled while covered under the benefits plans, the child's coverage may be continued as long as the child remains disabled and depends on you for support.

Making Enrollment Changes During the Year

In most cases, your pretax benefit elections are irrevocable and remain the same for the entire year (January 1–December 31). During each annual enrollment period, you will have the opportunity to review your benefits elections and make changes for the coming year.

During Annual Enrollment, you may make changes to your coverage such as adding or dropping coverage for yourself and any dependents or changing to other plan options (if eligible and available). **You must make a new Flexible Spending Account election each year.**

Certain coverages allow limited changes to elections during the year. These benefits include the medical, Flex–Medical, Flex–Dependent Care, vision and dental plans. Under these benefits you may make changes to your elections only during the year if you have a status change. Status Changes include:

- Marriage, divorce, or legal separation
- Gain or loss of an eligible dependent for reason such as birth, adoption, placement for adoption, court order, disability, or death;
- An event that causes a dependent to satisfy or cease to satisfy the eligibility requirements of the Plan, such as reaching the dependent age limits or any similar circumstance
- Changes in your spouse's employment or benefit coverage that affect benefits eligibility
- Changes in dependent's benefits eligibility

The change to your benefit elections must be consistent with the status change. **You have 30 days from the date of a status change to complete the online enrollment form. Notify Human Resources for instructions on how to make a change.** Otherwise, you must wait until the next annual enrollment period to make a change to your elections unless you experience a status change or HIPAA Special Enrollment event. In some cases, your election will become effective on the first day of the month following your request. If your change is the result of birth, adoption or placement for adoption, your election will become effective on the date of the event.

Pretax Payroll Deductions

To help offset your contributions for the Medical, Dental and Vision Plans, we offer these benefits on a pretax basis through the IRS Section 125. By making your contributions for these benefits on a pretax basis, the premium is withheld from your pay before federal, state (in most cases), and FICA taxes are calculated. This can reduce the amount of taxes you pay per paycheck.

How to get the most of your medical plan.

About Your Medical Coverage

Welcome to coverage through Blue Cross and Blue Shield of Texas' health plan for employees of ACU. You've chosen coverage with one of the most widely recognized carriers worldwide. For more than 60 years, the nationwide Blue Cross and Blue Shield family of independent plans has provided members with innovative health plans designed to meet their needs.

BlueEdge Health Care Account (HCA) is a BCBSTX medical plan combined with an employer-funded account, which reimburses you for covered medical expenses incurred by you, your spouse and your dependents. It's designed to give you more control and more choice in your healthcare decisions. By making the right choices and taking advantage of BCBSTX's network rates for covered services and discounts on non-covered services, you can control how much you spend on the healthcare you need.

BlueEdge HCA encourages you to be more actively involved in your health and wellness. It gives you more responsibility for the financial impact of your healthcare choices. As always, you should work with your physician to make healthcare decisions that are best for you. But now you can have more control over how your healthcare works – and more control over how your health care dollars are spent.

Over the next couple of pages, you will be provided an overview of your new benefits, along with many practical tips for taking advantage of everything BlueEdge has to offer – so you can take control of your health and well-being.

What Is the BlueCard® PPO Program?

Blue Cross and Blue Shield Association of plans gives you access to doctors and hospitals almost everywhere. Always carry your BCBSTX ID Card with you, even when you travel. You'll always find the care you need and you won't usually have to pay anything but deductibles, up front. More than 85 percent of all doctors and hospitals throughout the United States contract with Blue Cross and Blue Shield Plans. Outside of the U.S., you have access to doctors and hospitals in more than 200 countries.

How Does My Medical Plan Work?

You pay less out-of-pocket if you use the physicians, hospitals, and other healthcare providers that participate in the PPO network with Blue Cross and Blue Shield. While you don't need referrals or authorizations for most services, you receive the highest level of benefits when you use Preferred Providers. In some instances, such as inpatient hospital, mental health and substance abuse care, Blue Cross can require prior approval. In other words, Blue Cross and Blue Shield must approve the need for the care before you seek it. To find Preferred Providers:

- Visit the **www.bcbstx.com** web site and look for information about finding doctors or hospitals nationwide.
- Call **1.800.521.2227** to find out if the provider you select is Preferred.

Remember that you must pay more out of your pocket when you use Out-of-Network Providers. The chart in this booklet on page 8 shows a comparison between benefits when you use In-Network Providers and benefits when you use Out-of-Network Providers. Also keep in mind that your health plan pays the Allowed Price for services and supplies. In-Network Providers agree to accept the Allowed Price as payment in full. When you use Out-of-Network Providers, you must pay the difference between the Allowed Price and the provider's charge, or any amounts above Usual and Customary.

Benefits for most services require that you pay a deductible each year. Once you have met your Out-of-Network deductible, you share the cost of your care through coinsurance.

Once again, the coinsurance amount for Out-of-Network Providers is higher than the one for In-Network Providers. For In-Network Providers, you need only to pay the deductible for the plan year. For Out-of-Network providers, after you meet the deductible, you will have a coinsurance and out-of-pocket maximum to meet. Keep in mind, coinsurance is the component that tracks toward your out-of-pocket maximum, deductibles do not. Your preventative care is covered at 100% for in-network providers.

Inpatient/Preauthorization Notification

There are times when Blue Cross must give approval in advance for benefits to be considered. There are three types of approval: Pre-Admission Review, Emergency Admission Review and Continued Stay Review. To contact Blue Cross for approval, please refer to the phone numbers listed on the inside front cover of this brochure, or on your BCBSTX ID card.

All elective inpatient admissions must be preauthorized with the exception of maternity care related to delivery. The member's network provider is responsible for preauthorizing in-network care and approved out-of-network care. For other out-of-network or out-of-area care, the patient is responsible for calling a toll-free number to initiate the preauthorization process. Emergency admissions must be authorized within two business days, following the admission. Preauthorization is not required for outpatient procedures, 23 hour observations, Durable Medical Equipment (DME), and day surgeries.

What is a HCA and how does it work?

ACU funds your healthcare account. For individual coverage, ACU will contribute $1,000. For dependent coverage, ACU will contribute $2,000 into your personal account. That money is available to pay for medical expenses covered by your plan, so you spend less of your own money. If you spend the entire allowance contributed by ACU, you'll pay 100% for all medical services (excluding preventive care) until you've reached your deductible. Remember, that at any point (either using your HCA balance or paying out-of-pocket), you will be paying the BCBS discounted rate. Once you reach your deductible, the plan pays your remaining qualified medical expenses at 100%, assuming the charges are in-network charges. Out-of-Network charges will be paid at 70% until you meet your out-of-pocket maximum.

INDIVIDUAL COVERAGE EXAMPLE	DEPENDENT COVERAGE EXAMPLE
EMPLOYEE ONLY	EMPLOYEE + SPOUSE, EMPLOYEE + CHILD(REN), EMPLOYEE + FAMILY
PREVENTIVE CARE COVERAGE **-100% COVERAGE-**	PREVENTIVE CARE COVERAGE **-100% COVERAGE-**
ACU CONTRIBUTION INTO HCA **-FIRST $1,000-**	ACU CONTRIBUTION INTO HCA **-FIRST $2,000-**
YOUR RESPONSIBILITY TO REACH DEDUCTIBLE **-NEXT $3,000- ONLY IF HCA IS DEPLETED**	YOUR RESPONSIBILITY TO REACH DEDUCTIBLE **-NEXT $6,000- ONLY IF HCA IS DEPLETED**
REMAINING MEDICAL/Rx CHARGES AFTER $4,000 DEDUCTIBLE MET **-PAID AT 100%-**	REMAINING MEDICAL/Rx CHARGES AFTER $8,000 DEDUCTIBLE MET **-PAID AT 100%-**

*The above illustrations assume all medical charges are in-network.

Under these plans, all medical charges, including prescription drugs, track towards your deductible. In other words, when you go to the doctor's office, 100% of the charges are paid by you. Any dollars you have in your healthcare account can be used to pay for the charges. If you do not have a balance in your healthcare account, then you are responsible for the charges – up to $4,000 for employee only coverage and $8,000 if you are covering dependents. Once you have met your share of the deductible, you are not responsible for paying any further medical costs for the remainder of the year, assuming that your medical services and procedures are considered in-network.

The HCA is easy to use—the rest is up to you!

1. **Choose the right physician, facility or healthcare professional for your health care needs.** Remember, Blue Cross and Blue Shield has negotiated discounts with network physicians and facilities. Your healthcare dollars go a lot when you stay in-network.
2. **Take advantage of your preventive care coverage.** You and your family can stay healthy or detect problems early with routine physicals, regular exams or immunizations.
3. **Be prepared when you make, and arrive for, medical appointments.** Have your Blue Cross and Blue Shield ID card handy. Your doctor's staff may ask for your plan information, subscriber and group numbers when you call and they will copy your card when you arrive for your appointment. You also may want to bring a few prepared questions for your doctor, to get the most from your visit.
4. **Try to select doctors who submit claims for you.** Physicians and facilities in the BCBSTX network usually submit claims for you and then bill discounted charges, so your benefit dollars go further. If you use out-of-network professionals, you'll pay more and you may have to submit the claim yourself. When you submit a claim, you are reimbursed directly.
5. **Remember a few important facts about how your plan works.**
   - Once the money in your HCA is gone, you pay for all qualified medical expenses (except preventive care) up to the deductible amount. When you reach that amount, the remainder of your eligible medical expenses are paid at 100%.
   - Expenses from your own pocket for covered medical or prescription drug services, are applied against your deductible. Your preventive care expenses that are covered and paid by your plan are not applied.
6. **Understand your responsibility.** Many network doctors and others will bill you after they submit your medical claim and receive the Explanation of Benefits (EOB) that tells them exactly what you owe.
   - Some providers may ask you to pay up front for services if you have not met your deductible. **If your doctor requests that you pay up front, direct him/her to call 800.521.2227 and speak to a BCBS representative regarding your plan.**
   - You benefit from BCBS's negotiated discounts with network physicians, facilities, and other healthcare professionals. When BCBS receives their claim, they will apply the discount to their charges and your Explanation of Benefits will indicate exactly what your doctor was paid and whether you owe part of the fee. In the event your doctor charges you incorrectly, or he/she collects from you and also receives payment from BCBS, you should receive a refund from him/her for any overpayment you made.

Medical Schedule of Benefits—HCA PLAN

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible	$4,000 Individual/ $8,000* Family	
Out-of-Pocket Maximum	$0	$4,000 Individual/ $8,000 Family
Coinsurance	0%	30%
Inpatient Hospital (Semi-Private Room and Board)	0% after deductible	30% after deductible
Outpatient Facility	0% after deductible	30% after deductible
Emergency Room	0% after deductible	
Physician Office Visit/Exam	0% after deductible	30% after deductible
Preventive Care Services Annual Physicals Well Baby Care Well Child Visits (to age 6) Routine Vision Exam Routine Hearing Exam	0%, No deductible	30% after deductible
Inpatient/Outpatient Mental Health Services	0% after deductible	30% after deductible
Inpatient/Outpatient Serious Mental Illness Services	0% after deductible	30% after deductible
Lifetime Maximum	Unlimited	
Retail Prescription Coverage (30-day Supply) Generic Preferred Brand Name Non-Preferred Brand Name	0% after deductible 0% after deductible 0% after deductible	
Mail Order Prescriptions (90-day Supply)	0% after deductible	No Benefit

* No more than $4,000 in covered medical expenses for any individual in the family will apply to the family deductible.

HCA FUNDING		
	EE only	EE + Dependents
Annual Funding Amount	$1,000	$2,000

HCA CALENDAR FOR NEW HIRES	
Hire Date	HCA Amount (Individual/Family)
1st Quarter (1/1/2013 – 3/31/2013)	$1,000 /$2,000
2nd Quarter (4/1/2013 – 6/30/2013)	$750 /$1,500
3rd Quarter (7/1/2013 – 9/30/2013)	$500 /$1,000
4th Quarter (10/1/2013 – 12/31/2013)	$250 /$500

Blue Access for Members

Blue Cross and Blue Shield Online: www.bcbstx.com

The Blue Cross and Blue Shield of Texas website is your online guide to healthcare information. On the Blue Access for Members webpage, you can login and do the following:

- Check the status of a claim and your claims history.
- Confirm who in your family is covered under your plan.
- View and print an Explanation of Benefits (EOB) for a claim.
- Locate a doctor or hospital in your network.
- Select the option to stop receiving EOBs in the mail.
- Sign up to receive claim status email alerts.
- Request a new or replacement member ID card or print a temporary member ID card.
- Find and review outcome history procedures previously performed in hospitals.

It's Easy to Get Started

1. Have your group and member identification numbers ready – you can find these on your Blue Cross and Blue Shield ID card.
2. Go to www.bcbstx.com.
3. Log in to Blue Access for Members.
4. Create a user ID and password for immediate and secure access to your personal information.

When you log in to Blue Access for Members, you can view claim information for yourself and your spouse or dependents, if they are covered by your plan.

This is a summary of benefits. It is not a legal description and is provided only to assist in answering general questions. Other limitations and exclusions are listed in the Summary Plan Description, available from Human Resources.

How the BlueEdge HCA Might Look

An In-Network Individual Example:

Let's say, for the sake of discussion, that you have the following plan setup:

Deductible: $4,000
Amount in HCA: $1,000
Coinsurance: 100%
Out-of-pocket Maximum: $0
Now, let's say that you have a fairly typical year, at least as far as In-Network medical costs go.

Sample 2013 Medical Expenses

SERVICE	COST	PAID FROM HCA	PAID BY YOU	PAID FROM PLAN	HCA BALANCE
Routine Physical for Jane	$200	N/A	$0	$200	$1,000
Prescriptions for Jane	$200	$200	$0	$0	$800
4 Office Visits for Jane	$500	$500	$0	$0	$300

Your incurred medical costs: $900 on medical care
Your HCA covered: $700
BlueEdge covered: $200 (cost of routine physicals/preventive care)
Your out-of-pocket: $0
When subtracting the $700 in medical expenses from the $1,000 HCA balance, you are left with $300 in your HCA account. With the rollover feature, the leftover $300 will roll into 2014.

An In-Network Family Example:

Let's say, for the sake of discussion, that your 3-member family has the following plan set up:

Deductible: $8,000
Amount in HCA: $2,000
Coinsurance: 100%
Out-of-pocket Maximum: $0
Now, let's say that you have a fairly typical year, at least as far as In-Network medical costs go.

Sample 2013 Medical Expenses

SERVICE	COST	PAID FROM HCA	PAID BY YOU	PAID FROM PLAN	HCA BALANCE
Routine Physical for Jane	$200	N/A	$0	$200	$2,000
Prescriptions for Jane	$200	$200	$0	$0	$1,800
4 Office Visits for John	$500	$500	$0	$0	$1,300
6 Pediatrician Visits for Timmy	$200	$200	$0	$0	$1,100
Urgent Care Visit for Timmy	$700	$700	$0	$0	$400

Your incurred medical costs: $1,800 on medical care
Your HCA covered: $1,600
BlueEdge covered: $200 (cost of routine physicals/preventive care)
Your out-of-pocket: $0

When subtracting the $1,600 in medical expenses from the $2,000 HCA balance, you are left with $400 in your HCA account. With the rollover feature, the leftover $400 will roll into 2014.

Note: No one individual member met their $4,000 individual deductible. Jane – $400; John – $500: Timmy – $900.

24/7 Nurseline – Answering Your Healthcare Needs

Maintaining good health starts by asking the right questions at the right time. We all know that sometimes those questions come up unexpectedly, like when the doctor's office is closed. The 24/7 Nurseline provides you with 24-hours-a-day/7-days-a-week access to experienced registered nurses. You are also encouraged to use the 24/7 Nurseline audio library with more than 1,000 prerecorded health topics. You can reach the Nurseline by calling **1.800.581.0393.**

Special Beginnings – Maternity Management Program

Special Beginnings is a voluntary, confidential maternity program to help members better understand and manage their pregnancy. Call **1.800.462.3275**, to enroll in Special Beginnings.

- Personal telephone contact with an experienced obstetrical nurse.
- A pregnancy risk assessment.
- Pregnancy-related educational materials.
- A welcome packet full of congratulatory gifts.

Wellness Resources – Well on Target

Well on Target are specially designed wellness programs through BCBSTX. These programs include:

- Food and Exercise Diary
- Fitness Program Information
- Goals and Trackers
- Health Assessment
- Self-Directed Courses

Login to Blue Access for Members (BAM) to learn more about the wellness resources available to you!

Blue Care Advisors

Blue Care Advisors are a multi-disciplinary team of Registered Nurses, Licensed Professional Counselors and Licensed Masters-level Social Workers. The professionals reach out to at-risk and low-risk members to help:

- Simplify the coordination of healthcare benefits.
- Educate and empower members to make informed choices about your healthcare.
- Support wellness by helping members understand condition and preventive care guidelines, personal risk assessments and needed screenings.
- Facilitate behavior modification and readiness to change.

Disease Management

If you are living with a chronic health condition, you may face daily challenges in managing your illness. Help is available through our comprehensive Condition Management programs.

These voluntary programs are designed specifically for those who have been diagnosed with asthma, diabetes, cancer, congestive heart failure, chronic obstructive pulmonary disease, low back pain, metabolic syndrome (high blood pressure, high cholesterol and obesity), or coronary artery disease. Enrolling in a program can help:

- Decrease the intensity and frequency of your symptoms.
- Improve communication between you and your doctor about your health plan.
- Enhance your self-management skills.
- Enrich your quality of life.

Call **1.800.462.3275,** option 1, to enroll or to find out more about how Condition Management Programs can help you.

Additional Programs

Depending on your specific health condition and goals, the following additional programs may be available to you:

- Care Management: Focuses on traditional elements of medical care management for "at-risk" members.
- Case Management: Assists higher-risk members coping with a complex or catastrophic condition.
- Lifestyle Management Programs: Programs for Obesity/Weight Management, Tobacco Cessation and Stress Management are available. Wellness is promoted through a holistic approach of behavioral coaching, clinical coaching, education and condition management.

International Benefits

If you are enrolled in the BCBSTX Medical Plan, you are also covered while traveling abroad. For more information about your benefits while abroad, please contact Human Resources or the ACU Benefits Help Line (see page 3 for contact information).

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Prescription Drug Program

Retail Pharmacy Benefits

Under the BCBSTX prescription plan your prescription drug costs will apply towards the deductible. Once the deductible has been met, the prescription cost will be covered at 100% (assuming in-network providers). At the time you pick up a prescription, you will pay the BCBSTX allowed amount for that medication. You can check the BCBSTX cost of medications by logging into **www.bcbstx.com** and click on the "Learn More about your pharmacy benefits" link in the right-hand menu.

When utilizing this benefit, simply present your BCBSTX member card to any participating pharmacy. There will be no need to file claims. **Remember to give the pharmacist your BCBSTX ID card, because your prescription drug costs track towards your HCA plan deductible.**

Pharmacies may have different prices for the same prescription drug. It pays to shop around! By calling different pharmacies and providing your prescription drug coverage information, you may be able to find a lower cost at a different pharmacy.

For example, below are the retail costs (without insurance) for five commonly prescribed medications at 3 pharmacies in the Abilene area. These costs assume you are paying the full price and are before any insurance discounts or dispensing fees that may apply. Be aware that prices are subject to change at any time. This example is for illustrative purposes only and should not be relied upon.

	PHARMACY 1	PHARMACY 2	PHARMACY 3
Singulair (10 mg)	$164	$163.04	$161.94
Crestor (20 mg)	$159.07	$158.14	$157.07
Lipitor (20 mg)	$184.26	$183.16	$181.96
Lexapro (20 mg)	$145.63	$144.79	$143.79
Advair Diskus (100-50 mcg/dose, 14 EA Disp Pack)	$94.35	$93.86	$93.13

Mail-Order Program Benefits

If you use prescription drugs on a maintenance basis, you can save time and money by using the mail-order program. For a mail-order prescription drug form, please visit **www.mybensite.com/acu.**

Is there a resource available to help me calculate my prescription drug costs?

Currently and moving forward, you do have access to a prescription drug pricing calculator on BCBSTX's website. To access the website, please do the following:

1. Go to **www.myprime.com**
2. Click on the "Rx Price and Copay Calculator" link on the left side of the page. Enter your user ID (Banner ID) and password (date of birth). You will need to create a username/password to login (If you access the Prime Therapeutics website via the BCBSTX website, you will need to type in an email address).
3. Find "Drugs and Pricing Link" on the left-hand side. Enter the name of the drug.
4. The next screen will allow you to select strength, days supply and whether or not you will obtain through mail-order or at a retail pharmacy.
5. Once you fill in the detail, the following screen will provide you with the estimated cost and any generic equivalents.

Dental Coverage

Dental coverage at ACU is an **optional plan in which you may choose to participate at your expense**. The Blue Cross and Blue Shield of Texas Dental Plan helps you with the cost of many dental services, including orthodontia for your eligible child(ren) up to age 19.

With this dental plan, you are free to see any dentist you choose. Eligible benefits are paid subject to reasonable and customary charges. Although you are not required to use a network dentist, additional discounts may apply by doing so. To find a network dentist, go to **www.bcbstx.com** and click on "Find a Provider" and then "Find a Dentist," or call **1.800.521.2227.**

Preventive care, such as routine checkups and cleanings, is covered at 100% (within the Plan's reasonable and customary limits) with no deductible. Some services are subject to age and frequency limitations – see Plan for more details.

You must first meet a plan year deductible of $50 for basic and major services, then the Plan pays a percentage of the cost (within the Plan's reasonable and customary limits) for your dental care. It's always a good idea to ask for a predetermination of benefits for any services expected to exceed $300.

BENEFITS	SERVICE COST
Plan Year Deductible	$50 Individual / $150 Family
Annual Maximum Benefit	$1,000
Preventive Services Oral Exams and Evaluation Cleaning Fluoride Treatment Bitewing X-rays Space Maintainers	100% (not subject to deductible)
Basic Services Amalgams Composite Fillings Complete series or Panoramic Film x-rays Simple Extractions	80% (after deductible)
Major Services Osseous Surgery Crowns Inlays / Onlays Dentures Scaling and Root Planing	50% (after deductible)
Orthodontia Services (Child(ren) up to age 19) Lifetime Maximum Benefit	50% $1,000
Endodontics/Periodontics	Covered under major services

The BCBSTX dental network is "Blue Care Dental."

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Vision Coverage

Vision coverage at ACU is an **optional plan in which you may choose to participate at your expense.**

You can receive services from one of Vision Service Plan's thousands of eye-care professionals or choose to receive care outside of the Vision Service Plan network at a higher cost. To find a Vision Service Plan provider, call **1-800-852-7600** or visit Vision Service Plan's website at **www.vsp.com.**

You have a 12-month waiting period between each type of service and a 24-month waiting period between frames. For example, if you receive an eye exam on April 15, you will have to wait until the next April 15 before you may receive another exam.

Following is a brief outline of the Vision Service Plan benefits:

TYPE OF SERVICE	VISION SERVICE PLAN PROVIDER	NON-PARTICIPATING PROVIDER
Examination: **(Once every 12 months)**	A comprehensive vision examination is provided by a network optometrist or ophthalmologist after a $20 copay.	Member reimbursed up to $40
Frames: **(Once every 24 months)**	After a $20 copay, you choose from a selection of frames. If you select a frame outside of Vision Service Plan's covered-in-full selection, you will receive a $50 wholesale frame allowance at private-practice providers, or a minimum $130 retail frame allowance at a retail chain provider.	Member reimbursed up to $45
Lenses: **(Once every 12 months)**	If prescribed, a pair of single vision or standard lined multifocal lenses is covered for a $20 copay (combined with Frames copay).	Member reimbursed up to: Single Vision: $40 Bifocal: $60 Trifocal: $80 Lenticular: $80
Contacts: **(Once every 12 months)**	In lieu of lenses and a frame, you may select contact lenses. Vision Service Plan covers a wide variety of contact lenses from many leading manufacturers. Four boxes (12 pairs) of covered disposables are included when obtained from a network provider. A $120 credit will be applied toward the evaluation, fitting and purchase of non-covered contact lenses.	Member reimbursed up to: Medically necessary contacts: $210 Elective contacts: $105

Other Options

Should you choose other options not covered by the program, such as tints, progressive lenses, UV and anti-reflective coatings, **you will be able to purchase these options at a significant discount if you use a network provider.** This additional benefit may save you 20% to 40% off retail on additional lens options and lens upgrades.

Laser Eye Surgery

Vision Service Plan participants receive access to discounted refractive eye surgery benefits from numerous provider locations throughout the United States. To find a participating Laser Eye Surgeon in your area, visit the Vision Service Plan website at **www.vsp.com.**

Flexible Spending Accounts

What are Flex-Medical and Flex-Dependent Care Spending Accounts?

All ACU benefits-eligible employees may contribute to Flex-Medical and Flex-Dependent Care Spending Accounts, as designated by the federal Internal Revenue Code. Contributions are made through payroll deductions with before-tax dollars. When you contribute before-tax dollars, you decrease your taxable income and, thereby, increase your take-home pay.

ACU offers two types of Flex Spending Accounts:

- **Flex-Medical—** reimburses for the uncovered out-of-pocket or unreimbursed portions of qualified medical expenses.
- **Flex-Dependent Care—** reimburses for eligible expenses for dependent care with before-tax dollars. **The Dependent Care Flexible Spending Account is NOT for medical, dental, or vision expenses for your dependents.** It is strictly for the care of your dependents while you and your spouse are at work or attending school full-time.

How can Flex-Medical or Flex-Dependent Care Spending Accounts help me?

Your Flex Spending Accounts offer tax savings by allowing you to pay for qualified out-of-pocket expenses with before-tax dollars. Without a Flex Spending Account, you would still pay for these expenses, but you would do so using money remaining in your paycheck after taxes are deducted. For example:

Tax Savings Example

ACTUAL SAVINGS WILL VARY, BASED ON YOUR INDIVIDUAL TAX SITUATION	WITH FLEX ACCOUNT	WITHOUT FLEX ACCOUNT
Gross Salary	$40,000	$40,000
Health/Day Care Expenses (before-tax)	$5,600	N/A
Taxable Income	$34,400	$40,000
Tax (17.65%)	$6,072	$7,060
Net Salary	$28,328	$32,940
Health/Day Care (after-tax)	N/A	$5,600
Take-Home Pay	$28,328	$27,340
Your Tax Savings	$988	N/A

Flex-Medical Spending Account

Using pretax payroll contributions, you can receive reimbursement from your Flex-Medical Spending Account for eligible medical, dental, vision and hearing expenses incurred by you or an eligible dependent, as long as the expenses are not covered or reimbursed by other plans.

The minimum amount you may contribute to your Flex-Medical Spending Account is $260, and the maximum amount that you may contribute to your Flex-Medical Spending Account is $2,500. You can use the account to receive reimbursement for health care related expenses such as:

- **Deductibles under the HCA medical and Rx plan;**
- **Cost of eligible services above the reasonable and customary limits or above other plan limits; and**
- **Over-the-Counter medications, with a prescription.**

The IRS allows a 2½-month extension for Flexible Spending Plans to give you a longer period of time to use money in your flexible spending accounts. If you are a participant in the Flex-Medical program and you have a remaining account balance at the end of the year:

- **You will be given a 2½-month extension in which to incur qualified expenses.**
- **After the 2½-month extension, there will be an additional 45-day runoff period to submit expenses incurred during the previous plan year.**

This is a summary of benefits. It is not a legal description and is provided only to assist in answering general questions. Other limitations and exclusions are listed in the Summary Plan Description, available from Human Resources.

Flexible Spending Accounts (continued)

Flex-Dependent Care Spending Account

ACU offers an opportunity for you to save money on day care for eligible dependents through the Flex-Dependent Care Spending Account. You decide how much to contribute, up to $5,000 per year if married and filing together or a single parent. If you are married and filing separately, the maximum you can contribute is $2,500. To be eligible to use the account, you (and your spouse, if married) must work outside the home or attend school full-time.

Who is covered?

You may claim dependent care expenses for a dependent that lives with you and relies on you for more than half of his or her financial support. You must claim the person as a dependent on your federal income tax return. Eligible dependents include:

- **Child(ren) under the age of 13**
- **Disabled dependents of any age (such as your disabled spouse, older child, or parents)**

What care is covered?

You may be reimbursed only for day care that enables you to work, not occasional babysitters. If you are married, your spouse must also work, be a full-time student or be disabled. Eligible care includes care provided in:

- **Your home,**
- **Someone else's home, or**
- **A licensed daycare facility.**

You may be reimbursed for care provided by a relative, as long as the person is not your spouse, child under age 19, or someone you claim as a dependent on your federal income tax return.

How does reimbursement for orthodontics work?

If you complete the Discovery Benefits Automatic Orthodontia Request Form, you may receive automatic reimbursement for orthodontia expenses. Payments are issued at the beginning of each month for which services are still being provided. **If you are participating in automatic reimbursement for these expenses, the benefits debit card cannot be used to pay the provider.** The form may be found on the Discovery Benefits website **(www.discoverybenefits.com)** under "Printable Forms" for FSAs. This form must be completed and signed by both you and your orthodontist.

Is LASIK eye surgery a reimbursable expense under Flex-Medical?

Yes, LASIK procedures are reimbursable.

Why must my receipt state the date of service and type of service rendered in order to be reimbursed? Why isn't a copy of my paid receipt enough?

A Section 125 Plan states that services must be incurred during the incurral period, not when it is paid. Next year, ACU's incurral period is January 1, 2013 through March 15, 2014. Discovery Benefits must verify that the dates of service have occurred during the incurral period. The type of service determines the eligibility of the expense. You will have until April 30, 2014 to submit the claim for reimbursement.

If I terminate employment, or from the plan during the plan year, may I claim expenses I incur after my termination?

Once you terminate from the plan, expenses incurred after your date of termination are not reimbursable. You may submit expenses incurred prior to termination through the open claims period designated by ACU. In order to claim expenses incurred after your termination date, you must elect COBRA continuation for your Flex-Medical account. Flex-Dependent Care accounts are not eligible for COBRA continuation.

Flexible Spending Accounts (continued)

Are explanation of benefits provided by my insurance company sufficient forms of receipts?

Yes, explanation of Benefits (EOBs) are sufficient under most circumstances. If an EOB is returned to you and the insurance company has not paid any of the cost of services, Discovery Benefits may request more information than the EOB provides, such as a detailed receipt from the provider.

Are health-club dues reimbursable under a health-spending account?

No, dues are not reimbursable. But, the fee for a specific class that you participate in may be reimbursable with a letter from your physician stating the medical condition/disease that is being treated.

Can I use a dependent care FSA to pay for a babysitter in my home rather than using a day care facility?

Yes, you can include expenses paid to a babysitter if the services are necessary in order for you and your spouse, if married, to work, look for work, or for your spouse to attend school full-time. A babysitter cannot be someone you are able to claim as a dependent on your income taxes.

My underage 13-year-old child goes to daycamp during the summer. Is that qualified childcare?

Yes, if attendance at that camp allows you and your spouse to work, look for work, or for your spouse to attend school full-time.

Will ACU offer a debit card for use with my Flex-Medical Spending Account?

All ACU employees electing to participate in the Flex-Medical Spending Account program will receive a Flex-Debit Card. You may use the debit card like a credit card when paying for approved medical expenses. If any amounts remain unused in your accounts as of the end of the Plan Year (March 15, 2014) after all claims have been processed, you will forfeit the remaining amount. No additional substantiation is required for debit card transactions that are approved at merchants using IIAS. IIAS approves eligible medical expenses at the point of purchase matching the item's SKU to a list of eligible expenses. IIAS will require a second form of payment for ineligible expenses. For a list of IIAS merchants, visit Discovery's web site.

The debit cards may not be used at pharmacies that do not have IIAS in place. When you use your Discovery Benefits Debit Card to pay for expenses eligible under the flexible benefit plan at non-IIAS healthcare merchants (doctors' offices and dental and vision providers), Discovery Benefits receives limited information from your card purchase. Since the IRS requires more than this to properly substantiate an expense, Discovery Benefits may follow up with you to request more information about the expense in order to support the eligibility of the purchase.

I currently participate in the Flex-Medical Plan. How will the 2½-month Extended Grace Period for the Flex-Medical Plan impact my 2012 and 2013 funds in my Flex-Medical Account?

ACU has elected to offer our employees an additional 2½-month grace period to incur Flex-Medical expenses. This means you have an extra 2½-months past the end of the plan year to incur expenses (until March 15, 2013) for the 2012 plan year. To be eligible for the grace period, you must be an active participant in the Flex-Medical plan on the last day of the plan year (December 31, 2012). Discovery will apply your grace period expenses to your 2012 account balance first. Once your 2012 account is exhausted, your grace period claims will be applied to your 2013 election amount. This is also true for Discovery's debit card, which has the functionality to apply your grace period expenses to your 2012 account balance first and then to your 2013 account balance. Claims are processed in the order they are received. If you submit expenses or use your debit card for expenses incurred in 2013 before you submit all your 2012 expenses, your 2012 expenses may be later denied. That's because your remaining 2012 balance would have been used up paying off your new 2013 expenses. It is best to submit your prior plan year's expenses before submitting your new plan year's expenses or using your debit card for your new plan year's expenses.

Life and AD&D Coverage

Basic Life and AD&D

Your family will be protected by Basic Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance coverage, provided at no cost to all eligible employees by **Abilene Christian University.** Life Insurance is an important part of your benefits package and of your family's financial security. **ACU provides employer-paid Basic Life and AD&D coverage to all eligible faculty and staff at one times your annual salary.** You may purchase additional coverage by electing Optional Life Insurance or Optional AD&D Insurance.

After your death, your beneficiary will receive the amount of your Basic Life Insurance. If you have Basic AD&D coverage and suffer a covered injury, such as the loss of a limb or an eye, you would receive a portion of your Basic AD&D benefits. AD&D also pays a benefit if you die as a result of an accidental injury.

Who Is Your Life/AD&D Insurance Beneficiary?— Your designated beneficiary is the person(s) to whom you have assigned your Life and AD&D benefits. If you are not sure whom you selected as your beneficiary, you need to verify your beneficiary with the Human Resources Department. Be sure to check and update this information as necessary.

Optional Life and AD&D Insurance Choices for You

You can choose the following Optional Life and AD&D coverage for yourself:

- **Optional Life—** You may purchase additional group life insurance in $10,000 increments. Your coverage amount may not exceed five times your annual earnings, up to a maximum of $500,000. Coverage amounts over $200,000 require evidence of insurability. This coverage is portable, meaning you can take the coverage with you if you leave Abilene Christian University.
- **Optional AD&D—** You may purchase additional group AD&D insurance in increments of $10,000, up to $500,000 or ten times your annual earnings.

Rules for Evidence of Insurability (EOI) for You Are Below:

- If you are newly eligible for benefits and elect an amount that exceeds the Guaranteed Issue amount of $200,000, you will need to provide EOI that is satisfactory to Unum before the excess can become effective. If you elect less than the Guaranteed Issue amount, then no EOI is required.
- If you are currently enrolled in Optional Life coverage and there is no change in your election, then no EOI is required.
- If you are currently enrolled in Optional Life coverage and you want to increase your coverage level during Annual Enrollment, you will need to provide EOI for any amounts in excess of the Guaranteed Issue amount of $200,000.
- If you are not currently enrolled in Optional Life coverage, but were previously eligible and did not enroll and you want to enroll in coverage during Annual Enrollment, you will need to complete EOI for any amounts.

NOTE: Evidence of Insurability paperwork and processing is managed by Businessolver. If you make an election that requires the completion of an Evidence of Insurability form, you will receive an Evidence of Insurability letter and package from Businessolver. Follow the instructions for completing this information and return it to Unum within the stated time frame. If Unum does not receive all of the required information, they will re-request the missing information. If the missing information is not received within 30 days, your file will be closed.

If Unum does receive the requested information, a decision will be communicated to you directly. Unum will notify ACU of whether or not your request for additional coverage is approved. You will only be insured up to the Guaranteed Issue amount during the approval period. Payroll deductions will begin for the amounts that are not subject to EOI according to the terms of the plan. You will only be charged the new or additional monthly rate once Unum approves the amounts subject to EOI.

If you have any questions regarding the Evidence of Insurability application or the status of your medical underwriting, please contact Unum at **1.800.421.0344.**

Optional Life and AD&D Insurance Choices for Your Family

You may also choose Optional Life Insurance and AD&D Insurance coverage for your spouse and children. This coverage would pay a benefit to you in the event that your covered spouse or child(ren) passes away or suffers a covered injury. You pay the full cost of this coverage from your paycheck with after-tax dollars. **You must** select Optional Life and/or Optional AD&D for yourself in order to elect coverage for your spouse and/or children.

Life and AD&D Coverage (continued)

If you are not actively at work on the optional coverage effective date, your coverage will be delayed until you return to work. Similarly, if you request optional coverage for an eligible dependent and that dependent is confined to a hospital on the effective date, coverage may be delayed. Exception: Infants are insured from live birth.

The following are your choices for family life and AD&D insurance:

- **Spouse Life Insurance—** You may elect coverage for your spouse, in increments of $5,000, up to the lesser of 50% of your optional life coverage, or $250,000. Coverage amounts over $25,000 require evidence of insurability.
- **Child Life Insurance—** You may elect coverage for your eligible children up to $10,000, in $2,000 increments.
- **Spouse AD&D Insurance—** You may elect coverage for your spouse in increments of $5,000, up to the lesser of 50% of your optional AD&D coverage or $250,000.
- **Child AD&D Insurance—** You may elect coverage for your eligible children in increments of $5,000, up to the lesser of 50% of your optional AD&D coverage or $50,000.

Rules for Evidence of Insurability (EOI) for Your Spouse and Child(ren) Are Below:

- If you are newly eligible for benefits and elect an amount of Spouse Life that exceeds the Guaranteed Issue amount of $25,000, your spouse will need to provide EOI that is satisfactory to Unum before the excess can become effective. If you elect less than the Guaranteed Issue amount, then no EOI is required.
- If you are currently enrolled in Optional Spouse Life and/or Child Life coverage and there is no change in your election, then no EOI is required.
- If you are currently enrolled in Optional Spouse Life coverage and you want to increase your coverage level during Annual Enrollment, your spouse will need to provide EOI for any amounts in excess of the Guaranteed Issue amount of $25,000. If you are currently enrolled in Optional Child Life coverage and you want to increase your coverage level during Annual Enrollment, no EOI is required.
- If you are not currently enrolled in Optional Spouse and/or Child Life coverage, but were previously eligible and did not enroll and you want to enroll in coverage during Annual Enrollment, your spouse and/or child(ren) will need to complete EOI for any amounts.

NOTE: Evidence of Insurability paperwork and processing is managed by Businessolver. If you make an election that requires the completion of an Evidence of Insurability form, you will receive an Evidence of Insurability letter and package from Businessolver. Follow the instructions for completing this information and return it to Unum within the stated time frame. If Unum does not receive all of the required information, they will re-request the missing information. If the missing information is not received within 30 days, your file will be closed.

If Unum does receive the requested information, a decision will be communicated to you directly. Unum will notify ACU of whether or not your request for additional spouse life coverage is approved. Your spouse will only be insured up to the Guaranteed Issue amount during the approval period. Payroll deductions will begin for the amounts that are not subject to EOI according to the terms of the plan. You will only be charged the new or additional monthly rate once Unum approves the amounts subject to EOI.

If you have any questions regarding the Evidence of Insurability application or the status of your medical underwriting, please contact Unum at **1.800.421.0344.**

Salary-Continuation Death Benefit

This is an additional benefit provided by ACU that is extended to an employee's family in the unfortunate situation in which an employee passes away while employed by the University.

YEARS OF CONTINUOUS SERVICE	SALARY CONTINUANCE
Less than 1 year	0 months
1-2 years	1 month
3-4 years	2 months
5-6 years	3 months
7-8 years	4 months
9-10 years	5 months
11+ years	6 months

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Long-Term Care/Ancillary Benefits

Medical insurance is designed to cover the majority of medical expenses and pays the medical provider. With voluntary worksite-benefits, benefits are paid directly to the policyholder, unless otherwise assigned, regardless of any other insurance you may have. The money can be used to help cover medical expenses (copayments, deductibles, etc.), as well as non-medical expenses. **These various insurance policies are voluntary and are only offered during Benefits Annual Enrollment.** They are funded 100% by you through convenient payroll deductions. The policies described below are guaranteed-renewable and are fully portable for life including relocation, a new job and retirement.

Long-Term Care (LTC)— Unum

The need for assisted care can affect people at any age. For this reason, ACU has provided you the option of purchasing Long-Term Care insurance for yourself, your spouse, your parents, your grandparents, your spouse's parents and your spouse's grandparents. This program helps pay for expenses associated with nursing home and home health care. Some plan features of this benefit are:

- **Guaranteed standard issue**
- **Extended eligibility**
- **Guaranteed Renewable**
- **Choice of indemnity or reimbursement plans**
- **Total Choice Home Care Option** (covers professional and informal care, provided by the immediate family)
- **Free access to LTC connect—** an information and referral service for LTC concerns

Accident Insurance— Unum

Unum's Accident Insurance covers a wide range of injuries and accident-related expenses such as hospitalization, physical therapy, hospital intensive care, transportation and lodging plus coverage for:

- **Accidental death**
- **Catastrophic accidents that involve the loss of use of sight, hearing, speech, arms or legs**

These benefits are designed to help pay for out-of-pocket costs that may not be covered by traditional health insurance.

Whole-Life Insurance— Unum

Personal Security 2000, Unum's voluntary Whole-Life Insurance program, provides protection without the medical evidence of insurability that is often required before purchasing life insurance. Please check with the Benefits Help Line for eligibility and information on how to gain coverage on a guaranteed issue basis. This benefit is portable and allows you to lock in a rate and continue to pay the same rate at retirement or termination of employment. Rates are also available for spouse, children, and grandchildren.

Critical Care Insurance— Unum

Unum's critical illness insurance is a supplemental health insurance plan that is designed to provide a tax-free, lump-sum cash benefit at the first occurrence of seven (7) major critical illnesses including cancer, heart attack, and stroke. This benefit provides the pivotal financial support needed at the onset of a major illness, which can be used in any way, by the policy owner. This benefit is portable, which allows you to take the policy with you at a locked in, level rate. This coverage is also open to spouses and children of employees.

Additional information on all listed products can be found on the Benefits Website: www.mybensite.com/acu.

Disability Coverage

Voluntary Short-Term Disability (STD)

You are responsible for the cost of this coverage.

The university wants to ensure that every employee is empowered to take care of their family if they become ill or injured. What happens if you have an unexpected injury or illness that leaves you unable to work or earn a paycheck? Few people believe it will happen to them, but the truth is, your risk of becoming disabled is far greater than you may think.

If you are disabled according to your policy's definition of disability, you will be eligible to receive a weekly benefit based on a percentage of your weekly income. Your benefits will begin after 7 days of injury or 7 days of sickness and are paid as long as you meet the definition of disability for a maximum period of 25 weeks. Your benefit is paid based upon 60% of your weekly earnings to a maximum payment of $1,750 a week. The Plan will not cover any disability caused by, or resulting from a preexisting condition. A preexisting condition means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed medicines in the 3 months prior to your effective date of coverage, and the disability begins in the first 12 months after your effective date of coverage. The table below will assist you to calculate your monthly rate for coverage.

Evidence of Insurability (EOI) is required if you:

- Are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- Voluntarily cancelled your coverage and are reapplying.

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

SHORT-TERM DISABILITY COST CALCULATION

NOTE: If your weekly salary exceeds $2,917, use $2,917 as your weekly salary in the calculation.

_____	÷ 52 =	_____	x	_____	=	_____	
Annual Salary		Weekly Salary		Benefit %		Your Weekly Benefit	
_____	÷ 10 =	_____	x	_____	=	_____	
Your Weekly Benefit				Your Rate		Your Monthly Cost	

Employer-Paid Long-Term Disability (LTD)

ACU pays for LTD coverage for all eligible faculty and staff. The LTD benefit pays 60% of your total monthly earnings (less other income benefits) if you can't work due to a total disability. The maximum monthly benefit is $7,500. The minimum monthly benefit is $100. Benefits become payable on a monthly basis once you have been disabled for 180 days (when your Short-Term Disability, if any, ends). Benefits may continue while you are disabled up to age 65. In some cases, benefit payments may extend past age 65, depending on the age you become disabled. Benefits for disability due to mental health or based on self-reported symptoms are limited to 24 months. The Plan will not cover any disability caused by, or resulting from a preexisting condition. A preexisting condition means a condition for which you received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed medicines in the 3 months prior to your effective date of coverage, and the disability begins in the first 12 months after your effective date of coverage. Reduced benefits may be available for partial disability.

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

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Employee Assistance Program

Abilene Christian University recognizes that personal and family problems can impact your life both at home and at work. With more working couples and single parents, personal matters are harder than ever to manage. Baby sitters, child rearing issues, pressures of school, preparation for college, and aging parents all demand more of our time than we sometimes have.

When you face these challenges in life, and need help balancing work, home, personal or family issues, Unum's work-life balance program is available. To assist you and your family in getting the help you need, Abilene Christian University has established an Employee Assistance Program (EAP). Your EAP program is a confidential support service designed especially to help you with the issues that affect your life the most.

When you call the EAP toll-free number (**1.800.854.1446** for English **1.877.858.2147** for Spanish), you will be connected to a counselor who will help you clarify your problem, identify options, offer support and professional guidance, and help you develop an action plan. When needed, you will be offered an in-person appointment in addition to the telephone consultation. Your EAP team is staffed by professional counselors who are experienced in assisting people with a wide range of issues.

You can call toll-free anytime day or night and speak to a consultant. You can also logon to the website **w4.unum.com/worklifebalance** to find basic information on a number of valuable services.

You can access your work-life balance online resources at **www.lifebalance.net**

Enter the User ID: lifebalance

Password: lifebalance

What Types of Issues Can my EAP Assist Me With?

- **Parenting**
- **Care Giving**
- **College**
- **Relocation**

Additional Services Provided:

Help is available for non-acute emotional, mental or behavioral problems such as depression, anxiety, relationships or alcohol and drug problems.

An EAP consultant will help assess the situation and will provide telephone problem resolution consultations or may authorize up to three office visits with a counselor in your area. The consultant may also assist you in obtaining behavioral health treatment, if needed, through your health plan.

Ask your Human Resources representative to provide you with more information on this valuable service.

Additional information on all listed products can be found on the Benefits Website: www.mybensite.com/acu.

Other Benefits

Retirement Plans

For information on your retirement plans, please visit the TIAA-CREF website at **www.tiaa-cref.org/acu**. Below is a highlight of the benefit.

As a condition of employment, full and half time employees make a 2% of base pay mandatory contribution into a 403(b) retirement plan. In turn, the university will contribute 4% of an employee's base pay into the plan. Employees have the option of contributing an additional 1% or 2% of base pay into the 403(b) retirement plan. ACU will then contribute a corresponding 2% or 4% of an employee's base pay into the plan. This retirement option gives participants the freedom of allocation changes and a three-year cliff vesting.

EMPLOYEE CONTRIBUTION	EMPLOYER MATCHES
2% mandatory	4%
1% optional	2%
2% optional	4%

Supplemental Retirement Annuity

Employees may also choose to pay additional funds into a tax sheltered Supplemental Retirement Annuity (SRA). However, these funds are not matched by the University. SRAs may be elected at the participant's discretion; changes to the pretax deduction may be made at any time during the year. Any such election shall be effective with respect to Payroll Periods beginning after the Administrator's receipt of the completed election form. Contact Human Resources for more information.

Identify Theft

Identity theft is the fastest growing financial crime in America. In a matter of seconds, personal information such as a Social Security number, a credit card number, and/or an address can be stolen and used to obtain a new mortgage, line of credit, or additional credit card. Restoring one's name and good credit can be a time-consuming and expensive process.

Our goal at ACU is to work with vendors who use tools that help ensure your identity is kept safe. To further enhance our commitment to protect you and your family, ACU provides Identity Theft coverage to all benefits-eligible employees at no cost to you. We also give you the option to purchase this coverage for your dependents.

This service will offer income protection, reimbursement for allowable expenses related to the recovery of your identity, and a customer claims representative to aid you in the process of restoring your identity. We are happy to offer this program to assist you in the event that you are a victim of identity theft.

Adoption Assistance Plan

All regular, full-time employees are eligible for the ACU Adoption Assistance Plan. If an eligible employee and his/her eligible spouse both work at ACU, only one employee can utilize the benefit. Each eligible employee is eligible to receive up to $5,000 in adoption assistance benefits for the adoption of an eligible child. The limit is increased to $6,000 for an adoption of an eligible child with special needs (as defined by IRS regulations). The adoption assistance benefit shall be in the form of reimbursements for qualified adoption expenses, such as reasonable and necessary adoption fees, court costs, and attorney's fees. The Adoption Assistance benefit has a lifetime maximum limit of three adoptions per family. Please contact Human Resources for more information.

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Other Benefits (continued)

Holidays

All full- and half-time staff and reduced full-time employees are eligible for paid university holidays which are posted on the HR website at **www.acu.edu/hr.** The purpose of the policy is to provide competitive paid-time-off benefits and to recognize traditional holidays. Half-time employees will receive the holiday only if it falls during designated work hours.

HOLIDAY
New Year's Day
Martin Luther King Jr.'s Birthday
Spring Break (one day)
Good Friday
Memorial Day
Independence Day
Labor Day*
Thanksgiving (3 days)
Christmas (Christmas Eve and the week between Christmas and New Year's Day)

***Offices will be open on Labor Day because classes are in session. At the supervisor's discretion, an employee may use Labor Day as his/her holiday; however, offices must be sufficiently staffed because classes are in session. If an employee does not use this day as a holiday, it may be taken any time prior to the end of the fiscal year, May 31.**

Sick Leave

Sick leave accrues at the rate of 12 hours per month for all full-time and reduced full-time faculty and staff. The maximum time an employee may accrue is 1,040 hours. Sick leave may be granted for the employee or the care of an immediate family member. Sick leave may also be used by an employee due to a death in the immediate family of the employee or the employee's spouse.

Half-time staff employees working 20-39 hours per week accrue their sick leave allowance on the same basis as full-time staff employees, except it is prorated according to the number of hours worked.

Shared Leave Bank

The purpose is to provide a safety net against salary interruption for employees who have a catastrophic health condition (for themselves or immediate family) causing them to be unable to perform their assigned job duties. Donations of sick leave hours by employees provide income to an affected employee who would otherwise be on unpaid leave. The purpose is **not** to provide unlimited sick leave for any medical reason.

Other Benefits (continued)

Vacation

Full and half-time staff employees earn vacation based on years of service. Vacation leave is earned from an employee's first day of employment and may be taken after 6 months. Vacation accrues according to the schedule below. The next level of vacation is awarded on the employee's annual anniversary date.

YEARS OF SERVICE	AMOUNT OF VACATION
0 to 4	80 hours (6.67 hrs/month)
5 to 9	120 hours (10 hrs/month)
10 to 14	140 hours (11.67 hrs/month)
15+	160 hours (13.33 hrs/month)

Employee Tuition Benefit Program

Full-Time Employees and Reduced Full-Time Employees

Tuition discounts for education at Abilene Christian University is provided to all full-time and reduced full-time employees and their dependents based upon the length of employment with ACU. These tuition discount percentages will be calculated as follows:

1st Year of Employment	50% discount on tuition
2nd Year of Employment and thereafter	75% discount on tuition

Faculty and staff hired before 5/1/93, and continuously employed, are eligible for an 80% discount on tuition. The 80% discount does not apply to ACU Online Degree programs.

- **Full-time and reduced full-time employees** of Abilene Christian University are eligible to apply for a discount in tuition for courses taken at ACU for up to six hours during any fall, spring and/or the combined summer terms. If classes will take place during employee's scheduled working hours, the employee's supervisor must approve all classes before enrollment. Time spent in class will not be counted as part of the employee's work schedule, unless approved in advance by the employee's supervisor and vice president of the employee's area. The course must be taken outside scheduled working hours or an equivalent adjustment must be made in the employee's work schedule.
- **Spouses and Children of Full-Time and Reduced Full-Time Employees** – For classes taken at ACU, a full-time/reduced full-time employee may apply for a tuition discount for up to thirty-six credit hours for his or her spouse and children during the academic year.

Half-Time Employees

Tuition discounts for education at Abilene Christian University is provided to half-time employees and their dependents based upon the length of employment with ACU. Half-time employees are defined as employees who work between 20 and 31 hours a week or who are half-time faculty members. These tuition discount percentages will be calculated as follows:

1st Year – 4th Year of Employment	0% discount on tuition
5th Year of Employment and thereafter	50% discount on tuition

Faculty and staff hired before 5/1/93, and continuously employed, are eligible for an 80% discount on tuition. The 80% discount does not apply to ACU Online Degree programs.

- **Half-time employees** of Abilene Christian University are eligible to apply for a discount in tuition for courses taken at ACU for up to six hours during any fall, spring and/or the combined summer terms. If classes will take place during employee's scheduled working hours, the employee's supervisor must approve all classes before enrollment. Time spent in class will not be counted as part of the employee's work schedule, unless approved in advance by the employee's supervisor and vice president of the employee's area. The course must be taken outside scheduled working hours or an equivalent adjustment must be made in the employee's work schedule.
- **Spouses and Children of Half-Time Employees** – For classes taken at ACU, a half-time employee may apply for a tuition discount for up to thirty-six credit hours for his or her spouse and children during the academic year.

Applying for the Employee Tuition Benefit:

- An application must be completed once a year prior to the fall semester. This form may be submitted as early as March but must be submitted before or on the 12th day of class. Failure to do so will result in the loss of this benefit for the current semester. Applications can be completed online at www.acu.edu/hr.

To view the full Employee Tuition Benefit Program details, go to www.acu.edu/hr

Abilene Christian Schools (ACS) Tuition Benefit

Tuition grant of up to 80% for child(ren) of ACU employees. Employees may file an application at the time of enrollment each year with the ACS office.

This is a summary of benefits. It is not a legal description and is provided only to assist in answering general questions. Other limitations and exclusions are listed in the Summary Plan Description, available from Human Resources.

Frequently Asked Questions and Additional Resources

What should I do if I experience a claim problem or need help with other benefits-related issues?

Contact ACU Benefits Help Line: You can contact the dedicated ACU Help Line. The Help Line is your advocate for any medical, prescription drug, vision, dental and/or flexible spending account claims, billing and eligibility problems. You can reach the ACU Benefits Help Line at **1.866.99.HRTLC (47852)** or by email at **acuhelpline@ajg.com.**

Where can I find more detailed information regarding ACU's Benefits Program?

Visit **www.mybensite.com/acu** to review benefits, find useful contact information, print forms and much more.
Username: ACU **Password:** benefits

How do I change my benefits in the middle of the year when I have a status change?

1. Go to **www.my.acu.edu**
2. Log in using your MyACU login and password on the left side of the page.
3. Click on "Benefits Enrollment" under the Quicklinks on the left-hand side of the page.
4. Click on "Change my Benefits."
5. Then select the reason for changing your benefits and the date of the event.

Legal Updates

Newborns' and Mothers' Health Protection Act

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery, or from requiring the provider to obtain preauthorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymphedemas.

In addition, the Plan may not:

- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and copays consistent with other coverage provided by the Plan.

HIPAA Special Enrollment Rights

Loss of Other Coverage – If you are declining or have declined enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may in the future be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your non-COBRA coverage or your dependent's non-COBRA coverage. To be eligible for this special enrollment opportunity, you must request enrollment **within 30 days** after your other coverage ends or after the employer stops contributing towards the other non-COBRA coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption – 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/or your dependents. To be eligible for this special enrollment opportunity, you must request enrollment **within 30 days** after the marriage, birth, adoption, or placement for adoption.

Medicaid Coverage – The Abilene Christian University health benefits plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. TERMINATION OF MEDICAID OR CHIP COVERAGE- If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP- If the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than provide direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity, you must request coverage under the group health plan **within 60 days** after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

HIPAA Privacy Notice

HIPAA requires the Abilene Christian University Health Benefits Plan to notify you that a privacy notice is available by contacting Human Resources at **325-674-2359** or at **humanresources@acu.edu.**

Medicaid and the Children's Health Insurance Program (CHIP)

Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1.877.KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility.

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447
ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 1-907-269-6529
ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 1-602-417-5437
COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (i n state): 1-800-866-3513 Medicaid Phone (out of state): 1-800-221-3943
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588
INDIANA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948
IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Healthcare, then Medical Assistance Phone: 1-800-657-3629
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005
MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx Phone: 1-877-255-3092
NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: www.dhhs.nh.gov/ombp/index.htm Phone:603-271-5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid and CHIP
Website: http://www.ncdhhs.gov/dma Phone: 1-919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678
PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid
Website: www.ohhs.ri.gov Phone:401-462-5300
SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Website: http://health.utah.gov/upp Phone: 1-866-435-7414
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022, ext. 15473
WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third-Party Liability
WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare Phone:307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

Important Notice from Abilene Christian University about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Abilene Christian University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Abilene Christian University has determined that the prescription drug coverage offered by the Abilene Christian University Health Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Abilene Christian University coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Abilene Christian University coverage, be aware that you and your dependents will be able to get this coverage back during the annual enrollment period under the Abilene Christian University Health Benefits Plan.

When will you pay a higher premium (Penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Abilene Christian University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact your Human Resource representative at the information provided below. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Abilene Christian University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- **Visit** www.medicare.gov
- **Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.**
- **Call** 1-800-MEDICARE (1.800.633.4227). **TTY users should call** 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, **or call them at** 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 15, 2012
Name of Entity/Sender:	Abilene Christian University
Contact-Position/Office:	Wendy Jones Director of Human Resources
Address:	213 Hardin Administration Building ACU Box 29106 Abilene, TX 79699
Phone Number:	325.674.2359

2013 Benefit Monthly Rates

Medical / Prescription Drug

	BCBSTX—HCA
Employee Only	$50.00
Employee plus Spouse	$250.00
Employee plus Child(ren)	$175.00
Employee plus Family	$385.00

Voluntary Dental and Vision

	DENTAL	VISION
Employee Only	$28.85	$10.98
Employee plus Spouse	$58.55	N/A
Employee plus Child(ren)	$57.00	N/A
Employee plus Family	$86.70	$23.60

Voluntary Life / AD&D and Short-Term Disability

	EMPLOYEE / SPOUSE** VOLUNTARY LIFE RATES	VOLUNTARY SHORT-TERM DISABILITY RATES
Age	Rate per $1,000 Benefit	Rate per $10 Weekly Benefit
0— 24	$0.057	$0.51
25— 29	$0.057	$0.53
30— 34	$0.072	$0.50
35— 39	$0.102	$0.43
40— 44	$0.146	$0.48
45— 49	$0.232	$0.52
50— 54	$0.369	$0.59
55— 59	$0.568	$0.82
60— 64	$0.887	$1.10
65— 69	$1.541	$1.19
70— 74	$2.750	$1.19
75— 79	$2.750	$1.19
80+	$2.750	$1.19
Voluntary Child Life***	$0.28 per $1,000 of benefit	*Employee Voluntary Life and AD&D is available in $10,000 increments.
Voluntary Employee AD&D	$0.02 per $1,000 of benefit	** Spousal Life and AD&D is available in $5,000 increments.
Voluntary Spouse AD&D	$0.02 per $1,000 of benefit	*** Child Life is available in $2,000 increments.
Voluntary Child AD&D****	$0.021 per $1,000 of benefit	**** Child AD&D is available in $5,000 increments.

Voluntary Dependent Identity Theft

Spouse	$0.23
Spouse and Children ages 18-23	$0.40
Spouse and Children ages 0-23	$0.73

COBRA Rate Sheet

	HCA	DENTAL	VISION
Employee Only	$465.44	$29.43	$11.20
Employee plus Spouse	$930.89	$59.72	N/A
Employee plus Child(ren)	$892.77	$58.14	N/A
Employee plus Family	$1,197.82	$88.43	$24.07

This benefit summary prepared by

Gallagher Benefit Services, Inc.

thinking ahead