Augustana College

Employee Benefit Summary

September 1, 2016

DISCLAIMER

The intent of this summary is to briefly highlight your benefits and NOT to replace your insurance contracts or booklets. The information has been compiled into summary form to outline the benefits offered by your company.

If this benefit summary does not address your specific benefit questions, please refer to the Customer Service Contact page of this booklet. This page will provide you with the information you need to contact the specific insurance carriers and/or your Human Resources Department for additional assistance.

The information provided in this summary is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit summary does not constitute a contract.

The information in this booklet is proprietary. Please do not copy or distribute to others.

Contained within this document is your annual Medicare Part D notice as required by the Centers For Medicare & Medicaid. Please see the table of contents for page number.

Created by Holmes Murphy & Associates for Augustana College.

TABLE OF CONTENTS

WHO IS ELIGIBLE?

If you are a full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide through Augustana College.

Part-time employees working at least 20 hours per week are eligible for a partial benefits package.

HOW TO ENROLL

The first step is to review your current benefit elections. Verify your personal information and make any changes if necessary. Make your benefit elections. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

WHEN TO ENROLL

The open enrollment period runs from August 1 through August 23. The benefits you elect during open enrollment will be effective from September 1, 2016 through August 31, 2017.

HOW TO MAKE CHANGES

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, domestic partnership status change, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse or domestic partner, commencement or termination of adoption proceedings, or change in spouse's or domestic partners benefits or employment status. See HIPAA Special Enrollment Rights later in this packet for notification requirements.

MEDICAL INSURANCE-PLAN 1

PPO Plan

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Medical - This chart gives a side-by-side look at the amounts you pay when you use in-network and out-of-network providers.

Plan Feature	In-Network	Out-of-Network
Deductible (Calendar Year or Policy Year)	$1,250 single $2,500 family(any combination of two or more)	$2,500 single $5,000 family(any combination of two or more)
Coinsurance	You pay 20%	You pay 50%
Out-of-Pocket (Calendar Year or Policy Year)	$3,000 single $6,000 family(any combination of two or more)	$5,500 single $11,000 family(any combination of two or more)
Office Visit	$30 PCP copayment $50 Specialist copayment	You pay 50%
Physician Services (Includes Home Visits, Nursing Facility Visits, Allergy Testing, Hospital Visits, Surgical Procedures (Inpatient/Outpatient) and Maternity and Newborn)	You pay 20%	You pay 50%
Emergency Services	$150 copay, ded. waived	$150 copay, ded. waived
Facility Services	You pay 20%	You pay 50%
Outpatient Services	You pay 20%	You pay 50%
Chiropractic Services ($500 max per year)	You pay 20%	You pay 50%
Mental Health & Substance Abuse Services	Outpatient: $30 copay Inpatient: You pay 20%	You pay 50%
Retail Prescription Drug Coverage (30 day supply)	Tier 1: $10 Copay, 20% $25 Max Tier 2: $30 Copay, 30% $75 Max Tier 3: $50 Copay, 50% $125 Max Tier 4: 30%, $150 Max	Not Covered
For retail pharmacies, you will be responsible for one (1) co-payment for each 30 day supply prescription fill or refill, not to exceed a 90-day supply. For mail order pharmacy, you will be responsible for 2 co-payments for each 90-day supply prescription fill or refill.		

*** Deductibles do not apply toward the out-of-pocket maximum.**

**** Please refer to summary plan description in regard to more detail about your benefit plans.**

GENERIC INCENTIVE PROGRAM

OFFERED THROUGH NATIONAL PHARMACEUTICAL SERVICES (NPS)
SPECIAL OFFER TO OBTAIN CERTAIN GENERIC DRUGS FOR NO COPAYMENT!

We wanted to inform you of your eligibility for a special **Generic Incentive Program** being offered by your plan. Effective 9/1/2016 Augustana College will be offering a special **Generic Incentive Program** to employees or members of their households that are taking one or more selected brand name medications.

How does the Generic Incentive Program Work?
If you are currently taking a brand name medication to treat a particular condition, you will be offered an opportunity to try the therapeutically equivalent generic and have the co-pay waived for the generic medication for **THREE MONTHS**. This means that if you switch to a generic medication you will receive that medication at a zero-dollar ($0) copayment for switching. After three months, you will then pay the generic copayment, outlined in our prescription drug plan.

How long is the incentive provided for?
You are eligible to receive the incentive on medications filled through **November 30, 2016**. After the incentive expires, you will then continue to save money by paying your plan's generic copay for refills of the product. This special program offer expires on
November 30, 2016. Therefore, you will want to make sure that you have your new prescription for the generic alternative filled
before the above noted program expiration date to ensure you receive the reduced copay benefits of this program. The table below outlines potential drugs for the Generic Incentive Program:

Potential Targets for the Generic Incentive Program

BRAND MEDICATIONS	GENERIC ALTERNATIVES*
ANTIDEPRESSANTS *(for depression, aniexty or other conditions)* Celexa®, Lexapro®, Paxil CR®, Paxil®, Prozac Weekly®, Prozac®, Zoloft®	citalopram, fluoxetine, paroxetine, sertraline**
Wellbutrin XL®, Effixor, Cymbalta	bupropion SR
ANTIINFLAMMATORIES *(to treat pain and inflammation)* Celebrex®, Mobic®, Arthrotec®	etodolac, ibuprofen, naproxen or nabumetone
ANTIVIRALS *(to treat or suppress herpes simplex virus)* Famvir®, Valtrex®	acyclovir, famaclovir
ENDOCRINE/THYROID *(to treat thyroid conditions)* Levoxyl®, Synthroid®, Levothroid®, Unithroid®	levothyroxine
HYPERLIPIDEMICS *(cholesterol lowering agents)* Mevacor®, Zocor®, Pravachol®, Lescol®, Lescol XL® Lipitor®, Vytorin®, Crestor®	lovastatin, simvastatin**, pravastatin
PROTON PUMP INHIBITORS *(gastrointestinal disorders)* Aciphex®, Prilosec®, Nexium®, Protonix®, Prevacid®, Zegerid®	Prilosec OTC™, omeprazole OTC, omeprazole
NON-SEDATING ANTIHISTAMINES *(allergies)* Clarinex®, Clarinex D®, Zyrtec®, Zyrtec D®, Allegra®, Allegra D®	loratadine, cetirizine
ACE INHIBITORS *(for heart or high blood pressure conditions)* Aceon®, Altace®, Mavik®	lisinopril, benazepril, enalapril, moexipril
NASAL PRODUCTS *(allergies)* Rhinocort®, Nasonex®, Nasacort AQ®, Beconase AQ®	fluticasone, flunisolide

**Generic alternatives may not be the exact equivalent of a listed medication, however can be used for similar health conditions.*
***When generic is available in the marketplace.*
NPS also recommends tablet splitting opportunities be utilized when available and appropriate to maximize plan savings on generic and brand-name products.

What do I have to do to participate?
You will receive a letter in the mail from NPS, which will inform you of current generics available that qualify for the Generic Incentive Program. In some cases, your pharmacist may be able to offer the generic medication to you, while other cases may require a new prescription from your doctor. If you are unsure, we encourage you to contact your pharmacist or you may contact our customer service center at 1-800-546-5677. Prescriptions eligible for this program are processed as any other prescription. If you are eligible for the incentive, the claim will result in a zero-dollar copay at the pharmacy.

We encourage you to discuss your medication therapy with your healthcare provider to decide which medication therapy is best for you and your specific medical condition. You and your healthcare provider may decide that your current therapy is best for you. In this case, your prescription drug plan does provide a coverage benefit for you and/or your family; however, you will share in a greater portion of the cost of the medication through a higher copayment amount.

MEDICAL INSURANCE-PLAN 2

HSA-High Deductible Health Plan

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Medical - This chart gives a side-by-side look at the amounts you pay when you use in-network and out-of-network providers.

Plan Feature	In-Network	Out-of-Network
Deductible (Calendar Year or Policy Year)	$3,500 single $7,000 family(any combination of two or more)	$7,000 single $14,000 family(any combination of two or more)
Coinsurance	You pay 0%	You pay 10%
Out-of-Pocket (Calendar Year or Policy Year)	$3,500 single $7,000 family(any combination of two or more)	$7,500 single $14,000 family(any combination of two or more)
Child/Adult Wellness Care	Fully Covered	Deductible, 10%
Office Visit (Includes Home Visits, Nursing Facility Visits, Allergy Testing, Hospital Visits, Surgical Procedures (Inpatient/Outpatient), Maternity and Newborn)	Deductible, 0%	Deductible, 10%
Emergency Services	Deductible, 0%	Deductible, 10%
Facility Services	Deductible, 0%	Deductible, 10%
Outpatient Services	Deductible, 0%	Deductible, 10%
Chiropractic Services ($500 max per year)	Deductible, 0%	Deductible, 10%
Mental Health & Substance Abuse Services	Deductible, 0%	Deductible, 10%
Retail Prescription Drug Coverage (30 day supply)	Tier 1: Deductible, $0 Tier 2: Deductible, $0 Tier 3: Deductible, $0	Tier 1: Deductible, $0 Tier 2: Deductible, $0 Tier 3: Deductible, $0
For retail pharmacies and mail order pharmacy, prescription fill or refill will not exceed a 90 day supply.		

***Please refer to summary plan description in regard to more detail about your benefit plans.**

HEALTH SAVINGS ACCOUNT (HSA)

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What is a Qualified High Deductible Health Plan (QHDHP), and what is a Health Savings Account (HSA)?

A QHDHP protects you from catastrophic medical bills. This plan contains a deductible which must be met before the health plan provides coverage – this typically means that 100% of the charges you and your family members incur for health and prescription services are subject to the deductible – this plan has no copays for office visits, prescription, etc. The federal government has set various guidelines on the qualified deductible amounts, the rules on making withdrawals, etc. Please review all your medical plan information carefully, before enrolling in this plan.

Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (I.R.C. Sec. 223) was effective 1/1/2004. This law created a tax-advantaged trust or custodial account for the benefit of an individual covered under a QHDHP. Your Health Savings Account (HSA) is your own tax-exempt trust account that you can use to pay for your current medical expenses, including out-of-pocket expenses, coinsurance, and deductibles. Or, you may elect to save these HSA dollars for future unreimbursed expenses. *The choice is yours!*

How does an HSA work?

A HSA allows you to make tax-free payroll contributions to an account that you may then use to pay for certain out-of-pocket medical expenses. Paying for certain expenses with tax-free dollars reduces the amount you pay in taxes and increases your take-home pay. To be eligible to open an HSA, you must participate in a qualified High Deductible Health Plan. Your employer may also make deposits into your HSA, on your behalf. If this is your case, then you will need to subtract the employer HSA contribution from the annual maximum contribution amount, to determine what you may contribute through payroll deduction. Example: you are enrolling as a single in a HDHP, and your employer is contributing $500. You would subtract $500 from the annual maximum contribution of $3,350 to determine that you may contribute up to $2,850 of your own dollars.

Funds in your Health Savings Account accumulate on a tax-free basis, and, if the funds are used for *qualified* medical expenses, they are never taxed. This includes most medical care and services, dental and vision care, and also includes over-the-counter drugs. If you do withdraw HSA monies for *a non-qualified* expense, however, you would be subject to a 20% excise penalty, and you would be required to pay income taxes on the amount withdrawn. Please note that after you turn age 65, the 20% additional penalty no longer applies.

HSA monies may be used to pay for certain medical insurance premiums. Under today's tax laws, qualified premiums include: COBRA, qualified long-term care insurance, Medicare premiums and out-of-pocket expenses including deductibles, copays, and coinsurance for Part A (hospital and inpatient services), Part B (physician and outpatient services), Part C (Medicare HMO and PPO plans), and Part D (prescription drugs).

You can use the money in the account to pay for medical expenses for yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered by your HDHP.

NOTE: For those employees who enroll into a Qualified High Deductible Health Plan/Health Savings Account, you may only participate in the Health Care Flexible Spending Account on a *limited* basis: i.e., you may only defer expenses for dental and vision expenses, not medical services that are subject to the high deductible in the QHDHP.

Who is eligible to participate in a Health Savings Account?
There are several rules to follow that include but are not limited to:

1. You must be covered under a qualified high deductible health plan, that has the following features:
    a. Minimum deductible of $1,300 for single coverage; $2,600 for family coverage
    b. Maximum out-of-pocket of $6,550 for single coverage; $13,100 for family coverage
2. You may not be covered under any first-dollar medical plan (note: other types of insurance like specific injury insurance or accident, disability, dental, vision, or long-term care insurance are permitted)
3. You may not be enrolled in Medicare
4. You may not be claimed as a dependent on someone else's tax return

What is the maximum contribution that can be made to an HSA?
In 2016, $3,350 for self-only coverage, and $6,750 for family coverage. These amounts are adjusted annually for inflation. In 2017, $3,400 for self-only coverage, and $6,750 for family coverage.

In addition, individuals who are age 55 or older can also make "catch-up" contributions. The maximum annual catch-up contribution is as follows:
2013 and beyond – $1,000

What are the advantages of enrolling in a HDHP/HSA?
There are a number of advantages:

- Security – your high deductible health plan protects you in the case of catastrophic accident or illness.
- Affordability – the premiums for HDHP's are typically lower than a 'traditional' health plan.
- Flexibility – you may use the funds in your HSA to pay for current or future medical expenses.
- Savings – you can save the money in your HSA and have it grow on a tax-deferred basis.
- Control – you decide how to spend the money in your account, and, you decide how to invest the monies as well.
- Portability – your HSA account is completely portable, and goes with you if you would leave your current employer, if you become unemployed, if you change your medical coverage, move to another state, or change your marital status.
- Ownership – you own the funds in your HSA account, even the dollars your employer may contribute on your behalf. There are no "use it or lose it" rules for HSA's.
- Tax Savings – there are three ways your HSA account provides tax savings:
    - Your contributions go in tax-free
    - The monies earn interest on a tax-deferred basis
    - Withdrawals are tax-free for qualified medical expenses

DENTAL INSURANCE

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Dental

This chart shows how the plan works and how each type of service is covered.

Type of Service	Amount You Pay
Preventive Services	$0
Basic Services	$50 individual/$150 family deductible, You pay 20%
Major Services	$50 individual/$150 family deductible, You pay 50%
Orthodontia (Covers dependent children under the age of 19)	$50 individual/$150 family deductible, You pay 50%
Plan Maximum	$1,000 per calendar year for Preventive, Basic and Major Services $1,000 per lifetime for Orthodontia • Dependent Child Per
Waiting Periods	12 months for Major Services and Orthodontia

***Please refer to summary plan description in regard to more detail about your benefit plans.**

VISION INSURANCE

MetLife

You have the option of enrolling in our vision benefits. You must utilize services of a provider that participates in the provider network to receive benefits.

In-Network Plan Overview

Eye Exam (once every 12 months)

- Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a $10 copay.
- Retinal imaging:[1] Up to a $39 copay on a routine retinal screening performed by a private practice.

Frame (once every 12 months)

- Allowance: $130 after $25 eyewear copay
- Costco: $70 allowance after $25 eyewear copay
    - You will receive an additional 20% savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco.[1]

Standard Corrective Lenses (once every 12 months)

- Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after $25 eyewear copay.

Standard Lens Enhancements[1]

- Polycarbonate (child up to age 18) and Ultraviolet (UV) coating: Covered in full after $25 eyewear copay.
- Progressive, Polycarbonate (adult), Photochromic, Anti-reflective and Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at www.metlife.com/mybenefits.

Contact Lenses (instead of glasses; once every 12 months)

- Contact fitting and evaluation:[1] Covered in full with maximum copay of $60
- Elective lenses: $130 allowance
- Necessary lenses: Covered in full.

In-Network Value Added Features:

- Additional lens enhancements:[1] Average 20-25% savings on all other lens enhancements.
- Savings on glasses and sunglasses:[1] Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.
- Laser vision correction:[2] Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK, and Custom LASIK. This offer is only available at MetLife participating locations.

Out-of-Network

Eye exam: up to $45	Single vision lenses: up to $30	Lined trifocal lenses: up to $65
Frames: up to $70	Lined bifocal lenses: up to $50	Progressive lenses: up to $50
Contact lenses: Elective lenses: up to $105 Necessary lenses: up to $210	Lenticular lenses: up to $100	

(1) All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco to confirm the availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

(2) Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

***Please refer to summary plan description in regard to more detail about your benefit plans.**

FLEXIBLE SPENDING ACCOUNTS (FSA)

TRISTAR

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Plan Overview

Pre-Tax Premium Benefits

This plan allows you to fund several of your premium contributions with pre-tax dollars and to fund either a Health Care Reimbursement Account and/or Dependent Care Reimbursement Account. Your contributions are deducted from your gross wages before FICA, Federal and State taxes are deducted. You save money because you are taxed at a reduced income level. Your taxes are calculated after your premiums and reimbursement account monies are deducted from your gross wages.

Health Care Reimbursement Accounts

This plan allows you to defer pre-tax dollars into a Health Care Reimbursement Account to pay for certain IRS-approved medical care expenses not covered by your insurance plan with pre-tax dollars. Some examples include:

- Deductible, coinsurance and copayments
- Over the counter medications – with prescription
- Dental services and orthodontia
- Vision services, including contact lenses, contact lens solution, eye exams and eyeglasses
- Hearing services, including hearing aids and batteries

Medical Care Maximum: $2,550.00

Dependent Care Reimbursement Accounts

This plan allows you to defer pre-tax dollars into a Dependent Care Reimbursement Account. You may request reimbursement as you incur expenses to provide day care for qualified dependents: children under age 13, or an older disabled dependent child, or a disabled adult.

Dependent Care Maximums: $5,000 if married filing jointly or head of household; $2,500 if married filing single.

Plan Provisions

Please Note: Your election in the Augustana College Section 125 Flexible Benefit Plan is irrevocable for the entire plan year (September 1st through August 31st) without a qualifying change in status (i.e. birth, adoption, divorce, job status change, etc.) Please be advised that any unused FSA monies will be forfeited back to the Plan at the end of the plan year.

Extension

Your flex plan has a 2.5 month extension of time (at the end of the 12 month flex plan year), in which you may incur eligible flex expenses.

***Please refer to summary plan description in regard to more detail about your benefit plans.**

FLEXIBLE SPENDING ACCOUNTS

How do Flexible Spending Accounts Work?

Flexible Spending Accounts (FSAs) are like personal bank accounts. They allow you to set aside money for healthcare and/or dependent care expenses on a pre-tax basis. You can enroll in a Healthcare FSA and/or a Dependent Day Care FSA. Your election will cover you from your enrollment date through the end of the plan year unless you have a change in family status.

You can elect to have a portion of your salary withheld on a pre-tax basis for health or dependent care expenses you incur during the plan year. The funds will be placed into an account to be used during the year. If you contribute to both FSAs, you cannot use amounts contributed to one account to pay expenses eligible for payment from another account. For example, you cannot pay medical expenses from your Dependent Day Care FSA.

Health Care FSA

During annual enrollment you may elect to contribute monies into the Health Care FSA during the coming plan year. The amount you elect to set aside will be deducted from your paycheck in equal installments during the plan year.

Eligible health care expenses include copayments, deductibles, coinsurance, certain orthodontic procedures and other health-related expenses incurred by you or a family member. In addition, over-the-counter medicines are eligible for reimbursement with a prescription.

Dependent Care FSA

You can contribute up to $5,000 each year to the Dependent Day Care FSA to pay for dependent care expenses. The amount you elect to set aside will be deducted from your paycheck in equal installments during the coming year.

Eligible expenses are only those incurred for the care of a child under 13 years of age (or a disabled child older than age 13) who qualifies as your dependent for tax purposes; or, anyone you can claim as a dependent, such as an elderly parent or disabled spouse.

Use It Or Lose It

It is very important that you estimate accurately when determining how much to contribute to either FSA. FSAs can provide significant tax advantages for employees when the contributions are made on a pre-tax basis. For this reason the IRS requires that you use all of the money in your account(s) during the plan year. Any money remaining in your account(s) at the end of the plan year will be forfeited.

FLEXIBLE SPENDING ACCOUNT ELIGIBLE EXPENSES

Which expenses can be reimbursed by an FSA?
Your Health Care Reimbursement Flexible Spending Account lets you pay for medical care expenses not covered by your insurance plan with pre-tax dollars. The expenses must be primarily to alleviate a physical or mental defect or illness, and be adequately substantiated by a medical practitioner. The products and services listed below are examples of medical expenses eligible for payment under your FSA, to the extent that such services are not covered by your medical and dental insurance plan.

Unfortunately, **we cannot provide a definitive list of "qualified medical expenses."** A determination of whether an expense is for "medical care" is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

Under a rule that went into effect January 1, 2011, claims for over-the-counter medicine or drug expenses (other than insulin) cannot be reimbursed without a prescription. This rule does not apply to items for medical care that are not medicines or drugs.

- Abortion
- Acupuncture
- Alcoholism treatment
- Ambulance
- Annual physical examination
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery
- Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)
- Car modifications or special equipment installed for a person with a disability
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Crutches
- Dental treatment (not including teeth whitening)
- Diagnostic devices
- Disabled dependent care expenses
- Drug addiction treatment
- Eye exam
- Eye glasses
- Eye surgery
- Fertility enhancement (in vitro fertilization or surgery)
- Guide dog or other service animal
- Health institute fees (if treatment is prescribed by a physician)
- Intellectually or developmentally disabled care, treatment or special home
- Laboratory fees
- Lactation expenses
- Lead-based paint removal (if a child in the home has lead poisoning)
- Learning disability care or treatment
- Legal fees associated with medical treatment
- Lifetime care, advance payments or "founder's fee"
- Lodging at a hospital or similar institution

- Long-term care
- Medical conference expenses, if the conference concerns a chronic illness of yourself, your spouse or your dependent
- Medical information plan
- Medications, if prescribed
- Nursing home fees
- Nursing services
- Operations
- Optommetrist
- Organ donors
- Osteopath
- Oxygen
- Physical examination
- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Psychoanalysis
- Psychologist
- Special education
- Sterilization
- Stop-smoking programs
- Surgery
- Special telephone for hearing-impaired individual
- Television for hearing-impaired individuals
- Therapy received as medical treatment
- Transplants
- Transportation for medical care
- Tuition for special education
- Vasectomy
- Vision correction surgery
- Weight-loss program if it is a treatment for a specific disease
- Wheelchair
- Wig
- X-ray

Source: *www.irs.gov/publications/p502/ar02.html#en_US_publink1000178947*

Plans that do not allow reimbursement of all eligible medical expenses as defined by the IRS and Department of Treasury must customize this brochure prior to use.

FSA TAX SAVINGS WORKSHEETS

What will you do with the money you save by participating in the Flex Plan?

Use this worksheet to help determine your potential tax savings.

FSA Reimbursement Account Expenses							
Medical		**Vision**		**Dental**		**Dependent Care**	
Deductibles	$	Exams	$	Routine Exam	$	Children	$
Copays	$	Eye Surgery	$	Fillings/ Crowns	$	Adults	$
Prescriptions	$	Lenses/ Frames	$	Orthodontics	$		
Other	$	Contacts	$	Other			
Total	$	Total	$	Total	$	Total	$

Estimated Annual Expenses & Tax Savings		
Total Medical + Vision + Dental Expenses		$
Total Dependent Care Expenses	+	$
Total Expenses		$
Tax Bracket Percentage (see below)	X	
Annual Tax Savings		$
Number of Pay Periods	/	
Estimated Savings Per Pay Check		$

Tax Estimate Table	
Annual Household Earnings	**Estimated Tax Rate**
< $30,000	25%
$30,000 - $40,000	29%
$40,000 - $70,000	31%
> $70,000	33%

GROUP TERM LIFE

LINCOLN FINANCIAL GROUP

The college pays the premium for group term life insurance

Plan Overview

Basic Benefit Amount

1.5 times your Annual Compensation

Extended Death Benefit

If you become Disabled and are less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:

1. The date you are no longer Disabled.
2. The date you fail to qualify for Waiver of Premium or fail to provide proof of Disability as indicated under *Waiver of Premium.*

Waiver of Premium

If you submit satisfactory proof that you have been continuously Disabled for 6 months, coverage will be extended up to age 70.

Such proof must be submitted to us no later than 3 months after the date the Waiver Waiting Period ends. Premiums will be waived from the date we agree in writing to waive premiums for you.

After premiums have been waived for 12 months, they will be waived for future periods of 12 months, if you remain Disabled and submit satisfactory proof that Disability continues. Satisfactory proof must be submitted to us 3 months before the end of the 12-month proof.

Accelerated Benefits

Any benefits payable under this Accelerated Benefits provision will reduce the Death Benefit payable for Life Insurance. Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision.

Terminal Illness Benefit

We will pay a Terminal Illness Benefit if we determine you or your Spouse are Terminally Ill. The amount of this benefit is 75% of the Life Insurance Benefit in effect for you or your Spouse on the date we determine you are Terminally Ill up to the Maximum Benefit Amount shown in your Schedule of Benefits for this option. The Terminal Illness Benefit is payable only once in an Insured's lifetime.

Conversion Privilege for Life Insurance

Available. Please see Summary Plan Description for further information.

Age Reduction Schedule

Coverage reduces to 97.5% at age 65

Coverage reduces to 50% at age 70

***Please refer to summary plan description in regard to more detail about your benefit plans.**

VOLUNTARY LIFE INSURANCE

LINCOLN FINANCIAL GROUP

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself, you may also elect coverage on your dependents in this benefit, you pay the full cost through payroll deductions.

Voluntary Coverage Amounts

Employee may elect up to 5 times his/her annual salary

Minimum: $10,000
Maximum: $500,000
Multiples of: $10,000

Spouse may be covered

Minimum: $5,000
Maximum: $250,000
Multiples of: $5,000

Child(ren)

Minimum: $10,000
Maximum: $10,000

Guarantee Issue Amounts[(1)]

Employee: 5 times Annual Salary, up to $150,000
Spouse: $30,000
Child(ren): Under 6 months: $500, Over 6 months: $10,000

Waiver of Premium

Portability

Apply for within 31 days of termination.

Age Reduction Schedule

At age:	Benefits reduce to:
65	65%
70	50%

***Please refer to summary plan description in regard to more detail about your benefit plans.**

[(1)]The levels of Guarantee Issue (GI) coverage are available for employees & family members when the employee is initially eligible. At later annual enrollment periods, all applications for coverage are subject to approval by the carrier.

Employee/ Spouse Age	Employee Monthly Cost per $10,000 Unit	Spouse Monthly Cost per $5,000 Unit
Under 20	$0.50	$0.25
20 to 24	0.60	0.30
25 to 29	0.80	0.40
30 to 34	0.90	0.45
35 to 39	1.40	0.70
40 to 44	2.10	1.05
45 to 49	4.20	2.10
50 to 54	6.50	3.25
55 to 59	7.00	3.50
60 to 64	12.70	6.35
65 to 69	32.30	6.35
70 to 74	85.30	—
75 & over	170.70	—

The monthly cost for children is $2.00 for $10,000 of coverage. One premium will insure all your eligible children, regardless of the number of children you have.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

LINCOLN FINANCIAL GROUP

The college pays the premium for group accidental death and dismemberment insurance for each employee. The coverage under this policy varies with the age of the employee.

AD&D Coverage Amounts

Basic AD&D Benefits

Employee Principal Sum: 1 times Annual Compensation rounded to the next higher $1,000 if not already a multiple thereof, subject to a maximum of $400,000

Note: Changes in the Covered Person's amount of insurance resulting from a change in the Employee's amount of Annual Compensation take effect, subject to any Active Service requirement, on the September first following the change in Annual Compensation.

Schedule of Covered Losses

100% Covered: Loss of Life, Loss of Two or More Hands or Feet, Loss of Sight of Both Eyes, Loss of One Hand or One Foot and Sight in One Eye, Loss of Speech and Hearing (in both ears), Quadriplegia

75% Covered: Paraplegia

50% Covered: Hemiplegia, Loss of One Hand or Foot, Loss of Sight in One Eye, Loss of Speech, Loss of Hearing (in both ears)

25% Covered: Uniplegia, Loss of all Four Fingers of the Same Hand, Loss of Thumb and Index Finger of the Same Hand

20% Covered: Loss of all the Toes of the Same Foot

Coma

Monthly Benefit: 1% of the Principal Sum

Number of Monthly Benefits: 11

Lump Sum Benefit: 100% of the Principal Sum

When Payable: Beginning of the 12th month

Seatbelt and Airbag Benefit

Seatbelt Benefit: 10% of the Principal Sum subject to a Maximum Benefit of $25,000

Airbag Benefit: 5% of the Principal Sum subject to a Maximum Benefit of $10,000

Default Benefit: $1,000

Age Reduction Schedule

At age:	Benefits reduce to:
65	65%
70	50%

***Please refer to summary plan description in regard to more detail about your benefit plans.**

MATCHING YOUR LIFE INSURANCE TO YOUR NEEDS

The primary role of life insurance is to provide money for your family if you should die. As a first step in making your life insurance election, you'll want to look at your family's needs and determine the coverage amount that would be necessary to meet those needs if you were to die today.

1 You can start by figuring out the annual living expenses for your survivors. Experts suggest that their needs will probably equal about 75% of your current expenses. You may prefer to enter a different amount, depending on what you believe your survivors will need.

$ _____

Current Annual Expenses

X .75

$ _____

Survivor's Annual Expenses

+

2 Next, consider any future annual expenses that may come into play, such as college tuition. Add this amount to the current annual expenses.

$ _____

-

3 Subtract any annual income you expect your survivors to receive. This might include a spouse's income or Social Security or pension plans, if applicable.

$ _____

Estimated Annual Income Benefits

4 The result is an estimate of the amount your family would require to meet their ongoing needs.

$ _____

Estimated Amount to be Replaced by Life Insurance

LONG TERM DISABILITY INSURANCE

LINCOLN FINANCIAL GROUP

Long Term Disability Income Benefits

Augustana College provides full-time employees with one or more years of service long term disability income benefits, and pays the full cost of this coverage. In the event you become disabled, disability income benefits are provided as a source of income.

Plan Overview	
Benefit Amount	The lesser of 60% of your monthly Covered Earnings rounded to the nearest dollar or your Maximum Disability Benefit
Own Occupation Period	24 months
Elimination Period	180 days
Minimum Benefit Amount	The greater of $100 or 10% of your Monthly Benefit prior to any reductions for Other Income Benefits
Maximum Benefit Period	Varies based on the age disability occurs. Refer to your summary plan description for details
Maximum Benefit Amount	$6,000 per month
Pre-Existing Condition Waiting Period	3/12 applies to all employees covered less than 12 months. In the event of a claim, the carrier will review information from 3 months prior to the employee being insured on this plan; if the disabling condition had been treated or diagnosed, there would be no LTD benefits for the first 12 months. After that time, benefits will be payable according to the terms of the contract.

***Please refer to summary plan description in regard to more detail about your benefit plans.**

Employee Assistance Program

The purpose of the EAP is to help you prevent or solve personal problems that occur in your life. With the EAP through Genesis EAP, you have access to prepaid, professional services to help you deal with issues before they begin to affect your job performance or health. This benefit does not require enrollment and is immediately available.

Examples of problems/issues that you may receive assistance for include:

- Family or relationship
- Emotional or mental health
- Work-related concerns
- Substance Abuse and/or addiction
- Financial issues
- Legal issues
- Other problems that interfere with daily living

Simply Call: 800-475-1641

Counseling is available either by phone or at one of six Quad-Cities locations:

- 1910 East Kimberly Road, Suite 314
  Davenport, IA 52807

- 2535 Maplecrest, Suite 26
  Bettendorf, IA 52722

- 1127 North Second Street, Suite F
  Clinton, IA 52732

- 1008 11th Street
  DeWitt, IA 52742

- 2925 Cedar Street, Suite 2
  Muscatine, IA 52761

- 2100 18th Avenue, Suite 6
  Rock Island, IL 61201

Retirement Benefits

Retirement Benefit: The college has a 403(b) retirement savings plan to assist employees in setting aside funds to meet their individual retirement needs. During the first payroll after hire, new employees will be automatically enrolled in the plan at 4% of salary or wage, or can elect to defer a different percentage amount of a pre-tax or post-tax (Roth) basis. The college will match the first 4% of employee savings on a dollar-for-dollar basis. Employees can change their contribution levels at any time by contacting the payroll staff.

After one year of service, the college will begin contributing the equivalent of 7% of base salary or wage in addition to the matching contribution, for a total maximum contribution from the college of 11%. Employees who have been fully vested within a qualified employer plan within the last 12 months will be exempt from the one-year waiting period for the 7% college contribution.

All college contributions will be subject to a four-year graded vesting schedule. TIAA CREF is the recordkeeper and administrator of the retirement benefit. Employees will make investment allocation decisions through the TIAA-CREF website and changes to these allocations can be made at any time. More information on investment options is available at tiaa-cref.org/Augustana or by calling (800) 842-2252. Additionally, on-site workshops and counseling sessions are available on a regular basis.

Employee Education/Tuition Benefits

Augustana offers several education benefit options for full-time employees, their spouses or partners and their qualifying children. Each program has varied eligibility requirements. Cost and availability may vary based on the program and the participating school if an exchange if utilized. Meetings will be held on a periodic basis to answer questions and help employees who hope to use this benefit to understand the details for their particular situations. Further information on this benefit, including eligibility restrictions and dependent definitions, is available from the Office of Human Resources.

Augustana Tuition Remission
Full-time employees, their spouses or partners and eligible dependents receive 100% tuition exemption at Augustana after the employee completes **two** years of continuous full-time service at Augustana or four years of continuous full-time service at another college or university within one year of the date of employment at Augustana. The exemption applies after deducting scholarships and grants for which the student qualifies. This benefit does not cover fees, housing, room and board, or courses or experiences that are held off campus.

ELCA Tuition Exchange
Eligible dependents or full-time employees can receive tuition exemption at participating ELCA colleges and universities after the employee completes **two** years of full-time service at Augustana or four years of continuous full-time service at another college or university within one year of the date of employment at Augustana. Institutions may vary the way in which this exchange is calculated, and some ELCA schools choose to maintain an import/export balance that can limit availability.

National Tuition Exchange
Augustana participates in the National Tuition Exchange, which provides tuition exchange benefits with many colleges and universities across the country. This benefit is available to eligible dependents of full-time employees with **four** or more continuous years of service at Augustana. Eight years of continuous full-time service at another college or university within one year of the date of employment at Augustana also satisfies this requirement. This benefit does require that Augustana maintain an import/export balance, and frequently there is a waiting list for this benefit. An employee's ranking on the waiting list for the benefit is based on whether an employee has previously used the benefit and his/her years of service at Augustana.

Time-Off Benefits

Vacation: Eligible employees accrue vacation time for every full payroll period worked. The accrual amount varies based on length of employment, and new accrual rates are based on the anniversary date of the employee's hire. Part-time employees who work a schedule of 20 hours or more per week accrue vacation on a pro-rated basis. Part-time employees who are regularly scheduled for less than 20 hours per week do not accrue vacation.

- 0–5 years of employment: 120 hours (three weeks) of vacation
- 6–10 years of employment: 160 hours (four weeks) of vacation
- 11–20 years of employment: 200 hours (five weeks) of vacation

Vacation accruals will be provided on each employee's paycheck report. Vacation time cannot be used until it is accrued, and new employees generally are not permitted to take vacation time during the first three months of employment. Employees can continue to accrue vacation up to two times the yearly accrual. Vacation hours will not be accrued beyond this maximum and will be forfeited or lost. Employees will be paid for vacation hours that are accrued but not used at the end of employment with Augustana.

Administrative/exempt employees that work a nine- or 10-month schedule either accrue pro-rated vacation hours or observe academic breaks in lieu of vacation. These employees should work with their manager to understand department practices for time away from work.

Sick Time: Employees who work a 12-month schedule will be granted seven days (56 hours) of sick time on or around September 1 each year. Nine- or 10-month employees will receive six days (48 hours) of sick time. New employees will receive a pro-rated amount of sick time during their first year of employment. Sick time can be used for routine illnesses for the employee or a dependent child who lives in the home, as well as for appointments with a health professional. Unused sick time will roll into each employee's short-term disability bank on or around August 31 each year.

Short-Term Disability: Along with sick leave for routine illnesses, the college provides short-term disability leave of 80 hours (10 days) per year for serious health conditions of the employee or an eligible family member.

Additional information on policies and limitations on time off is available in the employee handbook.

Holiday Schedule for 2016-2017

The 2016-17 holiday schedule below indicates the days when offices will be closed. On these days only essential operations will be conducted.

The extra vacation days between Christmas and New Year's will result in a shutdown of one week. In some areas, it might be necessary for employees to work during this week in order to carry on vital college functions. If this is the case, you will be informed by your supervisor, and you will be entitled to double time for holidays and time and a half for extra days worked in addition to your regular pay.

Monday, September 5, 2016	LABOR DAY
Thursday, November 24, 2016 Friday, November 25, 2016	THANKSGIVING
Friday, December 23, 2016 Monday, December 26, 2016	CHRISTMAS
Tuesday, December 27, 2016 Wednesday, December 28, 2016 Thursday, December 29, 2016	EXTRA VACATION DAYS
Friday, December 30, 2016 Monday, January 2, 2017	NEW YEARS
Friday, April 14, 2017	GOOD FRIDAY
Monday, May 29, 2017	MEMORIAL DAY
Tuesday, July 4, 2017	INDEPENDENCE DAY

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage (including Medicaid and State Child Health Coverage)
If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth or 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 your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or State Child Health Coverage
If you or your dependents lose eligibility for coverage under Medicaid or State Child Health Coverage Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP or the determination of eligibility for a premium assistance subsidy.

> Example: When you are hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

ADDITIONAL PRODUCTS

If you or a family member is not eligible for your employer's medical plan, please feel free to contact Holmes Murphy & Associates for assistance in reviewing individual's health insurance options and making application for any of the following plans:

Plans:

Long Term Individual (under age 65) Medical Insurance
Affordable Care Act Subsidy Assistance
Medicare Supplement and Medicare Advantage Plans
Medicare Part D (Rx) Plans

Please Contact: (800) 247-7756

Holmes Murphy & Associates has assembled the finest staff of benefits professionals whose expertise is matched by their intelligence and integrity. We further arm them with continuous education, training, and cutting-edge technical resources. These highly specialized consultants have helped us build our reputation for excellence and fuel our growth.

HOLMES MURPHY®

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, please refer to your Employee Manual for additional information or contact your Benefits Manager.

IMPORTANT NOTICE FROM AUGUSTANA COLLEGE 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 Augustana College 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. Augustana College has determined that the prescription drug coverage offered by the Employee Health Care 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 15th to December 7th.

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 Augustana College coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Augustana College coverage, be aware that you and your dependents may be able to get this coverage back.

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 Augustana College 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact Human Resources for additional information. 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 Augustana College 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:	September 1, 2016
Contact:	Lisa Sears, Augustana College Human Resources
Address:	639 38th Street Rock Island, IL 61201
Phone Number:	309-794-7740

QUESTIONS & ANSWERS

Who do I contact with questions?

- Lisa Sears - Benefits & Leave Specialist, Human Resources
  Ph# 309-794-7740 and Email: lisasears@augustana.edu
- Ashley Osborn – Human Resources Assistant
  Ph#: 309-794-7352 and Email: ashleyosborn@augustana.edu

What is considered a qualifying life event?

- **Change in legal marriage status**: Marriage, Divorce/Annulment, Legal separation, Death of spouse, Domestic partnership
- **Change in dependents**: Birth, Death, Adoption
- **Gain or Loss of Other Group Coverage**: Medical, Dental, Vision
- **Change in Employment Status of Employee or Spouse**: Loss of employment, Termination/Rehire within 30 days, Change in part-time or full-time status, Leave of absence, Military leave that qualifies under the Uniformed Services Employment & Reemployment Act of 1994 (employee or spouse)

How to find a provider?

1. Go to **umr.com** and select **"Find a provider"**
2. Search for **UnitedHealthcare Choice Plus Network** using the alphabet navigation or type **UnitedHealthcare Choice Plus** into the search box
3. For medical providers, choose **Search for a medical provider**. For behavioral health providers (including counseling and substance abuse) select **View directory of behavioral health providers**.

UnitedHealthcare Choice Plus:

The UnitedHealthcare online provider directories include network hospitals, primary physicians and specialists. The following information is available:

- Provider name, address and phone number
- Hospital affiliation
- Board certification
- UnitedHealth Premium® Quality & Cost Efficiency designations that highlight physicians by quality of care and cost standards in their specialty
- Provider ID number
- Office language capabilities (English, Spanish, etc.)
- Map and directions to each office

Also, find provider on-the-go using the umr.com mobile site.

CUSTOMER SERVICE CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

MEDICAL:
Company Name - UMR
Phone Number – Please refer to back of ID card
Website – umr.com

DENTAL:
Company Name - UMR
Phone Number - Please refer to back of ID card
Website – umr.com

VISION:
Company Name - MetLife
Phone Number – 1-855-MET-EYE1 (1-855-638-3931)
Website – www.metlife.com/mybenefits

FLEXIBLE SPENDING ACCOUNTS (FSA):
Company Name - TRISTAR
Phone Number – 800-456-4584
Website – myRSC.com

LIFE/AD&D/LONG-TERM DISABILITY:
Company Name – CIGNA Group Operations
Phone Number – 1-800-557-7975

EMPLOYEE ASSISTANCE PROGRAM:
Company Name - Genesis
Phone Number – 800-475-1641 or 309-786-0492
Website – www.genesishealth.com/eap

RETIREMENT:
Company Name – TIAA-CREF
Phone Number – 800-842-2252
Website – www.tiaa-cref.org/augustana

PAID TIME OFF:
Company Name – Lisa V. Sears, Human Resources Benefits & Leave Specialist
Phone Number – 309-794-7740