YOUR BENEFITS

2020

SEWANEE
THE UNIVERSITY OF THE SOUTH

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BENEFIT BASICS

Introduction to Benefits

Benefits are an important part of the University's compensation program. Once eligibility requirements are met, employees with the following appointments are eligible for all benefits, including those as outlined for Tuition Remission and Exchange, and for the Secondary School Grant benefit:

- Full-time regular employees, including tenure track and tenured faculty;
- Term staff and contingent faculty with full-time appointments for more than 24 consecutive months who continue to work at least half-time after the 24th month.
- Part-time regular staff who are scheduled to work at least 3/4 time (1560 hours annually for non-exempt employees).

Staff members with an appointment of a minimum of 1,560 hours (3/4 time) are eligible to participate in the University's health plan. Contingent faculty members with a one year, full-time appointment are also eligible to participate in the University's health plan.

Staff members with a regular, part-time appointment who are scheduled to work at least 1000 hours annually are eligible to participate in the retirement plans. Term staff and contingent faculty members normally do not participate in the retirement plans unless they have held a full-time appointment for 24 consecutive months and continue to hold at least a half-time appointment.

An employee's benefit status is determined by his or her primary appointment. Multiple positions normally will not be combined to determine eligibility for benefits, and benefits earned in one position may not be used when an employee is working in a position that is not eligible for benefits.

Employees must notify the Office of Human Resources of a change in marital status, deletions or additions of dependents, or changes of beneficiaries.

Each employee should contact the Office of Human Resources as soon as possible after employment (no later than 30 days) to discuss eligibility for benefits and complete all necessary enrollment forms.

The following benefits are subject to IRS guidelines and are deducted from wages on a pre-tax basis:

- health insurance
- dental insurance
- vision insurance
- medical care spending accounts
- dependent care spending accounts

All fringe benefits and practices are subject to change at the University's discretion. Any benefit may be eliminated at any time and eligibility requirements and premiums may be adjusted at the University's discretion. If such changes occur, the University will attempt to advise employees and retirees in a timely manner. Questions concerning benefits should be directed to the Office of Human Resources.

Qualifying Life Events

Generally, you may only make or change your existing benefit elections during the open enrollment window. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- New entitlement to Medicare or Medicaid

You must notify Human Resources within 30 days of a qualifying life event. Depending on the type of event, you may need to provide proof of the event. Human Resources will let you know what documentation you should provide. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next open enrollment window to make changes (unless you experience another qualifying life event).

NEW FOR 2020

The University of the South is proud to offer new products and enhanced benefits to employees starting January 1, 2020. Below is what's new:

TrueLife Care Diabetes Management Program

TrueLife care proactively addresses daily behavior and self-care choices for individuals with diabetes to achieve and sustain better health. TLC coaches are experienced RN's trained to listen to questions and concerns, individually help and support each member with realistic goals for improvement and lifestyle maintenance. As a member of the program you will receive the following:

- Free glucometer
- Zero copays for test strips
- Free blood pressure meter and cuff
- Meal planning guides and tips
- Recipes and cookbooks specific to diabetes
- Educational tips and aids
- Video training aids
- Your own personal Health Coach

Call (888) 788-4925 to learn more and enroll today!

Telemedicine Through BlueCross BlueShield

PhysicianNow is a 24/7 service that provides access to board-certified doctors by mobile app, online video or phone. Whether you are at home, at work, traveling, or you simply want a more convenient way to see a doctor, it is easy to use and available anytime, anywhere! Visits require a $15 copay.

To access, download the mobile app or call 888-283-6691

Use PhysicianNow for:

- Allergies
- Cold and Flu
- Fever
- Sinus Infections
- Sore Throat
- Respiratory Issues

Common Pediatric Conditions Include:

- Cold and Flu
- Constipation
- Ear aches
- Diarrhea
- Nausea and vomiting
- Pinkeye

Diabetes Prevention Program through BCBST

The University is proud to offer a Diabetes prevention program through BCBST.

BCBST is partnering with Livongo to offer an online diabetes prevention program beginning 1/1/2020. It is FREE to eligible members and their dependents age 18 and older to help manage your weight and reduce your risk of developing type 2 diabetes. To access, download the mobile app or call 1-800-945-4355

Livongo Diabetes Prevention Program participants will get:

- Connected technology, including a cellular scale and mobile app
- Activity and food logging
- Health challenges
- Evidence based curriculum
- Community support
- Highly experienced and credentialed expert coaches
- Unlimited messaging and live one-on-one coaching sessions

If you have questions, contact Livongo Customer Support (available 24/7/365) at 1-800-945-4355 or via email at **membersupport@livongo.com.** Be sure to have your BCBST Member ID with you when you call.

BENEFIT COSTS

The company pays for some of your benefits and you share the cost for others, as shown below:

Live Well, Work Well Newsletters
We provide online tools and information to help you use your benefits wisely, save money, and make smart choices about the food you eat and staying active. The more you take care of yourself, the healthier we are as a group, which can reduce costs for us all.

BENEFIT	WHO PAYS	TAX TREATMENT
Medical Coverage	The University & You	Pretax
Dental Coverage	You	Pretax
Vision Coverage	You	Pretax
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	The University	After-tax
Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance	You	After-tax
Disability Coverage	The University	After-tax
Medical Care & Dependent Care Spending Accounts	You	Pretax
403(b) Retirement Savings Plan	The University	Pretax

HEALTH CARE COVERAGE

Eligible employees may choose to participate in the University's health plan, administered by BlueCross BlueShield of Tennessee. Coverage may be elected within 30 days of employment or during the annual open enrollment period (normally in November), in which case the change of coverage is effective on January 1. The employee pays the employee portion of the premium through payroll deduction. A detailed description of the plan is available from the Office of Human Resources.

Your Medical Plan

You have two medical plan options:

- BlueCross BlueShield of TN Option 1
- BlueCross BlueShield of TN Option 2

In-Network/Out-of-Network Coverage

Each medical plan features in-network and out-of-network coverage; individual and family deductibles; copays; coinsurance; and out-of-pocket maximums. Some offer a lower monthly cost, a higher deductible, and lower coinsurance amounts, while others cost more each month but offer a lower deductible and higher levels of coinsurance. If you don't understand some of these terms, please refer to the Glossary on page 24.

You may use in-network or out-of-network providers. You will always pay less if you see a doctor or receive services within the provider network because the plan pays more "in-network."

Deductible

You must meet an annual deductible before the medical plan begins to cover a portion of your costs. Once the deductible is met, the medical plan begins to pay for a percentage of covered expenses (this is called coinsurance).

Out-of-pocket maximums

Out-of-pocket maximums apply to all of the plans. This is the maximum amount you will pay for health care costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will fully cover eligible medical expenses for the rest of the benefits plan year (except for any copayments). If you see an out-of-network provider, you may be responsible for out-of-pocket costs that are considered above the "reasonable and customary" fees.

You decide which medical plan will work best for you and your family based on the monthly cost of coverage, the annual deductible and the out-of-pocket maximum.

Chat with BlueCross via Online Chat!

Connect with BCBST form your computer, tablet, or smartphone to ask questions about your health plan. Sign In to BlueAccess on bcbst.com/member and click the 'Chat with Us' icon to start a conversation.

MEDICAL PLANS

Eligible employees may choose to participate in one of the University's two medical plans, provided by BlueCross BlueShield of TN. Each plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs. Coverage in the plan begins on the first day of the month following an employee's hire. If selection is not made within 30 days of employment, employees must wait until the annual enrollment period (normally in November). The employee pays the total premium through payroll deduction. A detailed description of the plan is available from the Office of Human Resources.

	OPTION 1		OPTION 2	
Plan Provision	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual/Family)	$750/$2,250	$1,875/$5,625	$2,000/$6,000	$4,000/$12,000
Out-of-Pocket Maximum (Includes Deductible)	$4,000/$8,000	$10,000/$20,000	$5,500/$11,000	$11,000/$22,000
Lifetime Maximum	Unlimited		Unlimited	
Preventive Care	100%	40%*	100%	40%*
Primary Physician Office Visit	$25 copay	40%*	$30 copay	40%
Specialist Office Visit	$45 copay	40%*	$50 copay	40%
Office Surgery	$25/$45 Copay	40% after deductible	$30/$50 Copay	40% after deductible
X-Ray and Lab	No Additional Copay	40%*	No Additional Copay	40%
Inpatient Hospital Services	20%*	40%*	20%	40%*
Outpatient Hospital Services	20%*	40%*	20%	40%*
Ambulance Service	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency Care Services	$150 ER Copay	$150 ER Copay	$250 ER Copay	$250 ER Copay
Medical Equipment	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Behavioral Health (Inpatient/Outpatient)	20% after deductible/ $25 Copay	40% after deductible	20% after deductible/ $30 Copay	40% after deductible
Telemedicine	$15 copay		$15 copay	
Emergency Room Care	$150 ER copay	$150 ER copay	$250 copay	
Retail Prescription Drugs RX04 Network (30-day supply) Generic Brand Preferred Brand Non-preferred	 $15 copay $40 copay $65 copay	40%*	 $15 copay $50 copay $75 copay	40%*
Mail Order Prescription Drugs Plus90 or Home Delivery Network (90-day supply) Generic Brand Preferred Brand Non-preferred	 $30 copay $60 copay $110 copay	40%*	 $30 copay $80 copay $130 copay	40%*

*After deductible is met

Note: This is a summary only of your coverage. In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

2020 MONTHLY RATES

MEDICAL PPO PLAN - OPTION 1				
	Salary Tier	Employee Only	Employee + 1	Family
1	$14,820.00 - $19,999.00	$221.85	$441.58	$646.63
2	$20,000.00 - $25,365.00	$223.09	$444.04	$650.23
3	$25,366.00 - $39,999.00	$228.50	$454.83	$666.03
4	$40,000.00 - $54,999.00	$239.93	$477.57	$699.34
5	$55,000.00 - $69,999.00	$253.25	$504.07	$738.13
6	$70,000.00 - $84,999.00	$271.99	$541.37	$792.75
7	$85,000.00 - $124,999.00	$288.66	$574.59	$841.39
8	$125,000.00 and above	$304.17	$604.46	$885.52

MEDICAL PPO PLAN - OPTION 2				
	Salary Tier	Employee Only	Employee + 1	Family
1	$14,820.00 - $19,999.00	$107.47	$342.61	$501.72
2	$20,000.00 - $25,365.00	$123.96	$368.33	$539.39
3	$25,366.00 - $29,999.00	$155.05	$407.71	$597.05
4	$30,000.00 - $39,999.00	$183.38	$407.71	$597.05
5	$40,000.00 - $54,999.00	$215.15	$428.28	$627.16
6	$55,000.00 - $69,999.00	$227.17	$452.20	$662.19
7	$70,000.00 - $84,999.00	$244.64	$486.99	$713.15
8	$85,000.00 - $124,999.00	$259.04	$515.64	$755.10
9	$125,000.00 and above	$273.37	$544.79	$796.96

DENTAL			
Salary Tier	Employee Only	Employee + 1	Family
Not Applicable	$31.83	$61.16	$92.39

VISION			
Salary Tier	Employee Only	Employee + 1	Family
Not Applicable	$7.57	$10.97	$19.67

2020 BI-WEEKLY RATES

MEDICAL PPO PLAN - OPTION 1				
	Salary Tier	Employee Only	Employee + 1	Family
1	$14,820.00 - $19,999.00	$102.39	$203.81	$298.44
2	$20,000.00 - $25,365.00	$102.96	$204.94	$300.11
3	$25,366.00 - $39,999.00	$105.46	$209.92	$307.40
4	$40,000.00 - $54,999.00	$110.74	$220.42	$322.77
5	$55,000.00 - $69,999.00	$116.88	$232.65	$340.68
6	$70,000.00 - $84,999.00	$125.53	$249.87	$365.88
7	$85,000.00 - $124,999.00	$133.23	$265.19	$388.34
8	$125,000.00 and above	$140.39	$278.98	$408.70

MEDICAL PPO PLAN - OPTION 2				
	Salary Tier	Employee Only	Employee + 1	Family
1	$14,820.00 - $19,999.00	$49.60	$158.13	$231.56
2	$20,000.00 - $25,365.00	$57.21	$170.00	$248.95
3	$25,366.00 - $29,999.00	$71.56	$188.17	$275.56
4	$30,000.00 - $39,999.00	$84.64	$188.17	$275.56
5	$40,000.00 - $54,999.00	$99.30	$197.67	$289.46
6	$55,000.00 - $69,999.00	$104.85	$208.71	$305.63
7	$70,000.00 - $84,999.00	$112.91	$224.76	$329.15
8	$85,000.00 - $124,999.00	$119.56	$237.99	$348.51
9	$125,000.00 and above	$126.17	$251.44	$367.83

DENTAL			
Salary Tier	Employee Only	Employee + 1	Family
Not Applicable	$15.92	$30.58	$46.20

VISION			
Salary Tier	Employee Only	Employee + 1	Family
Not Applicable	$3.79	$5.49	$9.84

DENTAL PLAN

Eligible employees may choose to participate in the University's dental plan. Coverage in the plan begins on the first day of the month following an employee's hire. If selection is not made within 30 days of employment, employees must wait until the annual enrollment period (normally in November). The employee pays the total premium through payroll deduction. A detailed description of the plan is available from the Office of Human Resources.

It's important to have regular dental exams and cleanings so problems are detected before they become painful—and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

The University of the South offers you and your eligible dependents the opportunity to enroll in dental coverage through BlueCross BlueShield of Tennessee.

To find a provider participating in your dental plan network, visit bcbst.com and click "Find care now." Enter "dental" as your search criteria and then set your location.

Summary of Benefits	DentalBlue Network
Annual deductible Individual/Family *Applies to coverage B & C only	$50/$150
Annual Maximum per person	$1,000
Diagnostic and Preventive to include cleanings, fluoride treatments, sealants and x-rays	100%
Basic Services to include fillings, periodontics, scaling and root planning, oral surgery	80%
Major Services to include crowns, bridges, full and partial dentures	12 month Waiting Period 50%
Orthodontia (Child only up to age 19)	12 month Waiting Period 50%

VISION PLAN

Eligible employees may choose to participate in the University's vision plan. Coverage in the plan begins on the first day of the month following an employee's hire. If selection is not made within 30 days of employment, employees must wait until the annual enrollment period (normally in November). The employee pays the total premium through payroll deduction. A detailed description of the plan is available from the Office of Human Resources.

Your vision plan is provided through Vision Service Plan (VSP). It provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can see in-network or out-of-network providers; however, you always save money if you see in-network providers.

To find a VSP doctor or retail provider, visit www.vsp.com or call 800-877-7195. At your appointment, tell your doctor you have VSP.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Exam	$10 copay	Up to $45
Frequency Exam Lenses Frames	 12 months** 12 months** 24 months**	 Every 12 months Every 12 months Every 24 months
Prescription Glasses	$25 copay	N/A
Frames	$130 allowance; $150 allowance for featured frame brands; 20% savings on balance	Up to $70
Lenses Single vision lenses Bifocal lenses Trifocal lenses Lenticular lenses	 Covered at 100%* Covered at 100%* Covered at 100%* Covered at 100%*	 Up to $30 Up to $50 Up to $65 Up to $100
Medically necessary contact lenses	100%	Up to $210
Elective contact lenses in lieu of glasses	Up to $130 (copay doesn't apply)	Up to $105
Laser VIsion Correction	15% off regular price or 5% off promotional price	N/A

*Less any applicable copayment
**Beginning with the first day of the Benefit Period

MEDICAL & DEPENDENT CARE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) is a program that helps you pay for health care and dependent care costs using tax free dollars.

Employees are eligible to participate in the medical care spending account and/or the dependent care spending account if the employee is eligible to participate in the University's health care plan. For the medical care spending account, the participant must have been employed for at least six consecutive months and the employee's employment must be expected to continue the entire plan year.

Important Information About FSAs

Your FSA elections are effective from January 1 through December 31. Claims for reimbursement must be submitted by March 15 of the following year. Please plan your contributions carefully. Any money remaining in your account as of March 31 will be forfeited. This is known as the "use it or lose it" rule and it is governed by Internal Revenue Service regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

ACCOUNT TYPE AND ELIGIBLE EXPENSES	ANNUAL CONTRIBUTION LIMITS	BENEFIT
MEDICAL CARE FSA Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over the counter medications)	Maximum contribution is $2,750 per year	Saves on eligible expenses not covered by insurance; reduces your taxable income
DEPENDENT CARE FSA Dependent care expenses (such as daycare, after school programs or eldercare programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

Example

Here's a look at how much you can save when you use an FSA to pay for your health care and dependent care expenses.

ACCOUNT TYPE	WITH FSA	WITHOUT FSA
Your taxable income	$50,000	$50,000
Pretax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes*	$15,696	$16,350
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses and taxes	$32,304	$31,650
Tax savings with the Medical and Dependent Care FSA	$654	N/A

*This is an example only; not your actual experience. It assumes a 25% federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary, and are not included in this example. However, you will save on any state and local taxes as well.

LIFE & DISABILITY INSURANCE

What would your family do if your income was lost due to death or disability? Life and disability insurance are important for your financial security.

Life and Accidental Death & Dismemberment Insurance (AD&D)

Term life insurance, equal to an employee's annual salary rounded to the next higher thousand and limited to $100,000 coverage is provided by the University to eligible employees on the first day of the month following the date of hire. Coverage is reduced to 65% of the benefit amount at age 65, and 50% of the benefit amount at age 70. The reduced amount will be adjusted to the next higher multiple of $1,000 if the figure is not already a multiple of $1,000. Life insurance coverage is reduced to $5,000 at retirement. A description of the term life insurance plan is available in the Office of Human Resources.

AD&D insurance provides payment to you in the event you are involved in an accident that results in a covered loss that causes a permanent impairment, or payment to your beneficiary in the event you are involved in a covered accident resulting in your death. AD&D coverage is provided as a secondary component with the previously mentioned life insurance coverage in an amount equal to the life insurance benefit.

Supplemental life and AD&D insurance and dependent supplemental life and AD&D insurance are also available. Information on these programs is available from the Office of Human Resources.

Voluntary Life and AD&D Insurance Coverage

In addition to the University paid insurance, you have the opportunity to purchase additional life insurance for yourself, spouse and dependent children through payroll deductions. Employees must enroll in order to elect coverage for their spouse or children.

Annual Enrollment

Employee Coverage: For an employee who is currently enrolled, any increase of more than one level ($10,000) above the current benefit level will be subject to Evidence of Insurability. For an Employee who previously declined coverage, any increase above the current benefit level will be subject to Evidence of Insurability

Spouse Coverage: For an employee who is currently enrolled, any increase of more that one level ($5,000) above the current benefit level will be subject to Evidence of Insurability.

ACCOUNT TYPE	BENEFIT
Employee	• Increments of $10,000 • Guaranteed Issue: $200,000 • Maximum Benefit $500,000
Spouse	• Increments of $5,000 • Guaranteed Issue: $50,000 • Maximum Benefit: $250,000 • Cannot exceed 50% of employee's life amount
Child(ren)	• $10,000 Benefit • $500 maximum benefit for children less than 6 months old

This chart applies to newly eligible employees only.

Long-Term Disability Insurance

Long-term disability insurance provides disability income to eligible employees after a disabling illness or injury of six-months' duration.

Premiums are paid entirely by the University, and an employee must work at least 30 hours per week and meet other requirements to be eligible for coverage. Coverage is effective the first day of the month following the date of hire. A description of the long-term disability insurance plan is available from the Office of Human Resources.

After an employee has been unable to work as a result of an illness or injury for a year's duration, the employee normally will be considered terminated.

COVERAGE AND BENEFITS
LONG-TERM DISABILITY Covers 60% of your base annual earnings, to a $7,000 maximum Benefits begin after 180 days of disability or illness and continues to the earlier of recovery or the later of your Social Security Normal Retirement Age or the maximum Benefit Period listed in your certificate.

EDUCATIONAL BENEFITS

Employees are encouraged to develop their skills and increase job knowledge and expertise.

General Educational Development or General Education Diploma (GED)

The University will pay the tuition, as well as the cost of materials and examination fees, for any employee to take instruction in any regular program directed toward high school certification.

The University of the South Courses in Undergraduate Programs in The College & The School of Theology:

Eligible employees may take for credit or audit, at no cost (except for necessary books and supplies or special fees), any undergraduate course in the College of Arts and Sciences or any graduate course in the School of Theology for which the necessary prerequisites have been satisfied. During the second and third years of employment, employees may only take one course per semester for credit. After three years of employment, supervisors have the responsibility for limiting the number of credit hours so that an optimum level of job performance is maintained.

The eligibility requirements for courses at the University of the South are:

- The employee must be at least a three-quarter time employee and have worked for at least one year prior to course enrollment. A retired employee who has met the age and service requirement for University post-employment benefits is also eligible to receive the benefit.
- The employee must meet the eligibility requirements of the College of Arts and Sciences or School of Theology to enroll as a special student.
- For non-exempt staff members, time off for a University of the South course must be made up unless the head of the division in which the staff member works and the Director of Human Resources approve. Exempt employees are expected to work all the hours necessary to fulfill their duties when taking University of the South courses.
- Enrollment in the course must be approved by the employee's supervisor who must also approve any special work schedule prior to enrollment.

Procedures for applying for this benefit are:

1. Employees should complete the "Employee Tuition Remission" form which is available in the Office of Human Resources and on its webpage prior to registration each semester and have it approved and returned to the Office of Human Resources within two days following registration.
2. Employees are normally enrolled as Special Students during the academic year and are required to register with the Associate Dean for Undergraduate Academic Affairs of the College of Arts and Sciences or the Associate Dean for Academic Affairs of the School of Theology. Employees wishing to enroll in Summer School are required to register with the Director of Summer School for courses in the College of Arts and Sciences and the Director of the Advanced Degrees Program for courses in the School of Theology.

The University of the South Courses in The School of Letters:

Each year, a maximum of two scholarships will be available to employees interested in enrolling in the School of Letters.

The eligibility requirements for a scholarship in the School of Letters are:

- The employee must have been continuously employed for at least one year and be a regular or term employee working at least three-quarter time prior to course enrollment.
- The employee must be accepted into the School of Letters. The supervisor and division head of the employee must support the application and confirm that attending the School of Letters will not interfere with the employee's duties.

EDUCATIONAL BENEFITS (continued)

Procedures for applying for this benefit are:

1. Employees must apply for admission to the School of Letters by February 15.
2. Employees must submit a scholarship request to Human Resources by March 15. This request must contain a statement describing how a degree from the School of Letters will support his or her work at the University and his or her future career plans. The employee must also ask his or her supervisor and division head to send a statement of support to Human Resources.
3. Final decisions on awarding scholarships will be made by the School of Letters Employee Scholarship Committee.

To renew the scholarship in subsequent years, employees must submit a renewal request to the School of Letters Employee Scholarship Committee by March 1. Renewal of the scholarship will depend on successful work in the School in previous summers.

Undergraduate Courses at Other Colleges and Universities:

Limited funding is available for employees wishing to pursue undergraduate programs at accredited universities, colleges, junior colleges, technical or vocational schools and who have not yet earned a degree. Employees interested in this program should discuss his or her interest with Human Resources.

The Office of Human Resources will assist the employee with a proposal describing the program being pursued, the length of time required to achieve the degree, the long-term benefit to the University if the employee earns the degree, and the opportunities for growth at the University this program could provide the employee. To ensure that the proposal will benefit the University, the Position Management Team will review the proposal and may award a scholarship up to one-half the cost of tuition with a maximum of $12,000 per person. The University will pay one-fourth the tuition upon registration and the remaining one-fourth upon successful completion of the course with a grade of C or better. Under current tax laws any benefit greater than $5,250 in a calendar year must be treated as taxable income.

Scholarships will be awarded only to the extent that funding is available. If an employee is selected for this program, an interest-free loan will also be available to assist the employee with tuition not covered by the scholarship. Employees who receive this award are required to repay the scholarship if they leave the University before serving three years following receipt of the degree. Scholarship recipients who terminate their employment before completing their degree must also repay the scholarship

The eligibility requirements for receiving funding are:

- The employee must complete a year of service as a regular full-time employee prior to enrollment.
- Any special work schedule arrangements must be cleared with the employee's supervisor prior to enrollment.
- If the employee will qualify for grants or scholarships, the employee must apply for them. The amount of University funding will be reduced by the amount of the grant or scholarship.

Employees not wishing to pursue a degree may be eligible to receive the one-half tuition benefit for up to one work-related course per semester. Those interested in taking a single course should contact Human Resources.

Funding for Advanced Degree Programs

Limited funding is available for assisting employees with at least three years of full-time continuous service who wish to pursue an advanced degree. Employees interested in this program should submit a proposal to Human Resources describing the degree being pursued, the length of time required to achieve the degree, and the opportunities for growth at the University this program could provide the employee. To ensure that the proposal will benefit the University, the Position Management Team will review the proposal and may award a forgivable interest free loan of up to $35,000, or $12,000 on an annual basis, to offset the tuition for the program. Repayment of the loan is due when the employee terminates his or her employment with the University or if the employee fails to complete degree requirements. For each year the employee works after the degree is awarded, 10% of the loan is forgiven. If the employee works 10 years, the obligation for repaying the loan is met.

EDUCATIONAL BENEFITS (continued)

Educational Benefits For Spouses And Children

The University of the South

The University provides complete tuition remission for on-campus, undergraduate courses in the College of Arts and Sciences or any graduate course in the School of Theology for the spouses and dependent children of full-time employees whose appointment is for a period of one year or more, subject to the student's being in good standing and the student's degree-seeking status. Spouses and dependent children who have not previously received a four-year undergraduate degree are eligible for remission for courses taken at the University as part of an undergraduate degree-seeking program, and must be accepted for matriculation to be eligible. Spouse and dependent children who are not seeking a degree are eligible for remission for a maximum of two courses per semester. Continuation of this remission is subject to the same academic and other standards as the continuation of need-based financial aid. These same spouses and dependent children are eligible for portable financial aid for off-campus Advent or Easter semester programs, subject to the same standards as apply to students on financial aid.

The spouses and dependent children of disabled and retired employees who had met the age and service requirement for University post-employment benefits are also eligible under the same terms above.

To be considered a dependent child, he or she must be the natural, adopted or step-child of the employee, be under age 24, receive more than 50% of his or her support from the employee, and have lived with the employee for at least ½ of the year. Evidence of paying more than 50% of support is normally shown by the employee taking the child as a dependent on his or her federal income tax return.

Procedures for applying for this benefit are:

1. Employees should obtain the "Spouse-Dependent Tuition Application" form available from the Office of Human Resources and on its web page, and have it approved and returned to the Office of Human Resources prior to registration each semester.
2. Spouses and dependent children studying on a part-time basis follow the registration procedures established for Special Students and must contact the Associate Dean of the College. Those enrolled as full-time students follow the established registration procedures for full-time students.

EDUCATIONAL BENEFITS (continued)

The Tuition Exchange Program

The University participates in both the national Tuition Exchange (TE) Program, involving schools throughout the United States, and in the Associated Colleges of the South (ACS) tuition exchange program, involving most ACS member schools. These undergraduate programs provide the opportunity for dependent children of University employees to receive tuition scholarships at other participating institutions.

For the national TE Program, the annual value of the grant varies among participating institutions; however, it cannot be less than a stated minimum in any given year. (This figure is available from the Office of Financial Aid.) For the ACS program, the value of the grant at participating institutions is full tuition. Most member institutions in both programs are liberal arts colleges, although some more specialized institutions also participate. The Office of Financial Aid has lists of those institutions participating in either or both programs. (Some institutions, like the University, have dual participation.) Due to restrictions inherent in both programs, some member institutions may not, in given years, be able to participate in tuition exchanges. Interested employees should contact the Office of Financial Aid beginning in the fall of each dependent's senior high school year for details on participating institutions.

The eligibility requirements for this benefit are:

- The student must be the natural, adopted or step-child of the employee, under age 24, receive more than 50% of his or her support from the employee, have lived with the employee for at least ½ of the year, and have been claimed as the employee's dependent on at least one of the preceding two years' federal income tax returns.
- A student(s) whose parent is a full-time employee of the University hired for at least a year is eligible.
- A student(s) whose parent is a University retiree (living or deceased) is eligible providing section 1 above was met while the parent was an active employee.

Procedures for applying for this benefit are:

1. Obtain from the Office of Financial Aid the list of participating institutions to determine which schools will be participating in tuition exchanges.
2. The Office of Financial Aid will certify the eligibility of your dependent child to the school or schools under consideration.
3. The Tuition Exchange Liaison Officer of the receiving institution(s) will notify both the student and the Office of Financial Aid of acceptance into or rejection from the particular tuition exchange program.
4. In September, the Office of Financial Aid will provide the Office of Human Resources a list of all dependents receiving a Tuition Exchange. By October 1st, the employee must submit to Financial Aid or Human Resources documentation on the value of the scholarship.
5. Both tuition exchange programs are renewable annually, usually up to a four-year maximum, provided the student meets the stated academic standards of his or her institution for continuance of the tuition scholarship. At many institutions the process of admission into the institution is separate from the process of receiving a tuition exchange scholarship, and that an offer of one neither implies nor guarantees an offer of the other. (Typically, an offer of a tuition exchange scholarship follows an offer of admission or is contingent upon a subsequent offer of admission.)

EDUCATIONAL BENEFITS (continued)

The Educational Loan Program

The University offers an interest-free loan plan to all eligible employees who are enrolled or have dependents enrolled in degree-granting programs at accredited post-secondary educational institutions. Employees may borrow from a minimum of $500 to a maximum of $12,000 per academic year per dependent, not to exceed four academic years of borrowing per dependent. Loan repayments will be by payroll deduction for a period of up to 24 months per annual loan. Upon notice of termination of employment, the employee must pay the balance of the loan in full. This balance will be deducted from any payments owed the employee.

The eligibility requirements for this benefit are:

- All regular full-time employees who are in good credit standing with the University are eligible to apply for a loan under the Educational Loan Program (ELP) after one year of employment, provided there is a reasonable expectation that employment will continue beyond three years.
- A family's adjusted gross income (AGI) as reported on their most recent federal income tax return will be used to determine income eligibility for the ELP. A family must show sufficient resources (by use of a standardized needs analysis) to repay the ELP in order to qualify.
- The student for whom the ELP is sought must have been claimed as a dependent on the borrower's federal income tax return for at least one of the two years preceding the loan application, and he or she must be the natural, adopted or step-child of the employee, under age 24, receive more than 50% of his or her support from the employee, and have lived with the employee for at least ½ of the year.
- The student for whom the ELP is sought must be enrolled in a program at an accredited post-secondary educational institution.

Procedures for applying for this benefit are:

1. Obtain from the Office of Financial Aid an application for the ELP. When completed, the form must be returned to the Office of Financial Aid, along with a copy of the borrower's most recent tax return, a statement of the dependent's cost of education for the requested loan period, and the student's financial aid award (if applicable).
2. When the loan is approved, the borrower must sign a promissory note and a payroll deduction authorization form.
3. Loan disbursements will be made payable to the applicant at times corresponding to the enrollment period(s) covered by the loan.

The Secondary School Grant

The Secondary School Grant is designed to assist dependents of full-time employees hired for at least one year in attending an independent school of their choice for secondary education, excluding home school and online educational programs. The amount of the grant is determined each year, and the grant amount will vary depending upon where the student enrolls.

Repeated grades will not be covered and repayment will be required if student is withdrawn before end of term.

The eligibility requirements are the same as those for the Tuition Exchange Program.

Any student eligible for a scholarship or grant from the independent school must declare the amount of the grant in order to receive a University grant, and the amount of the scholarship or grant may reduce the University's grant.

Procedures for applying for this benefit are:

1. As soon as the student has been admitted to an independent school, the University employee parent or the guardian of a deceased employee's dependent should submit to Human Resources the completed "Secondary School Benefit Request" form that may be obtained from the Office of Human Resources or its website.

ADDITIONAL INFORMATION

Athletic Facilities And Events

The University's athletic facilities, including the Fowler Center, are available for use on a scheduled basis by all University employees. Employees will be admitted with their Sewanee ID Card. Spouses and eligible dependents may obtain Fowler Center cards for a processing fee from the Athletic Department. These cards may also be used for admittance to home football games.

Library Privileges

All employees are entitled and encouraged to use the facilities, services, and materials of the University Library. These include:

- Checking out books: Employees may check out regular stack materials and materials from the government information collection for sixteen weeks, subject to recall. Fooshee/Browsing books may be checked out for five weeks.
- Checking out videos: Employees may check out up to three videos for one day.
- Checking out audio material: Audio CDs may be checked out for three days. Books on tape or CD may be checked out for five weeks.
- Use of online resources: Employees may use any of the online indexes, databases, and other resources made available via the Library's web site: **http://library.sewanee.edu.**
- Checking out equipment: Employees may check out certain audio visual equipment and laptop computers, subject to availability. Equipment returned late may subject the employee to a fine. Equipment that has been damaged (i.e., beyond normal wear and tear) or lost while checked out to the employee will be repaired or replaced at the employee's expense and deducted from pay.
- Other library services available to employees include interlibrary loan, reference services, computing equipment and printing, scanning equipment, and video editing equipment. The use of these services and materials by employees will be governed by the library's policies.
- If any checked out item is lost, the employee will be charged the cost of the item, plus a processing fee, both of which will be deducted from pay

RETIREMENT PLANS

The University of the South 403(b) Retirement Savings Plan offers an easy way to save for your future through payroll deductions.

403(b) Retirement Plan

Eligible employees participate in the University of the South Retirement Plan administered by TIAA. The waiting period for the plan is one year from the date of employment, at which time enrollment in the plan is required and automatic. The one-year service requirement will be waived if the employee worked full-time at a four-year college or university for the 12-month period immediately prior to date of employment with the University

Contributions are paid during working years to provide income during retirement. Each employee has the opportunity to choose among several investment options.

If death occurs before retirement, the employee's beneficiaries (listed with provider/s) will receive accumulated retirement contributions and the earnings from these contributions. Detailed information on this program is available from the Office of Human Resources.

Note: Episcopal clergy normally participate in the Church Pension Fund, but may make optional tax-deferred elective contributions to the 403(b) Plan.

Employer Contributions

Upon completion or waiver of the waiting period, eligible employees will receive a contribution equivalent to 10% of his or her base salary.

Optional Tax-Deferred Retirement Plans

Employees may also be eligible to begin contributing on a voluntary basis to an additional tax-deferred retirement account (up to Internal Revenue Service limits) on the first day of the month following the date of employment or anytime thereafter.

Vesting

Vesting is immediate upon enrollment for both Employer and Employee contributions.

For More Information
For additional details about the 403(b) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, please refer to contact information below.

Call
800-842-2252

Visit
https://www.tiaa.org/sewanee

RETIREMENT PLANS (continued)

Emeriti Retirement Healthcare Program

The Emeriti Consortium is a non-profit program, developed by higher education leaders through the support of the Andrew W. Mellon Foundation, to provide health insurance during retirement years.

Eligible employees may make voluntary contributions to an Emeriti Health Account. Funds accumulated in an Emeriti Health Account can be used to offset the cost of future retiree medical expenses.

As a member of the Consortium, the University will contribute to an Emeriti Health Savings Account for employees who hold regular positions that are, at minimum, half-time and full-time employees who are over 40 years old and have five years of continuous service with the University.

Post-Retirement Benefits

An employee is eligible for standard retirement benefits if the employee has attained either (a) 65 years of age and has completed at least 10 consecutive years of full-time service, or (b) 62 years of age and the sum of age and years of full-time service is at least 80.

Eligible employees receive the following standard benefits upon retirement:

- Health Insurance at Full Cost Until 65. Retirees may continue to participate in the University Health Plan until age 65, selecting among the same options for themselves and/or their families, paying the full cost (University and employee premiums). Only those retirees (and dependents) who are enrolled in the health plan on the date of retirement may continue in the plan; retirees who drop the University's plan may not reenroll.
- Educational Benefits. Retirees and their eligible spouses and dependent children are eligible for educational benefits on the same basis as current employees.
- Life Insurance. Retirees are eligible for $5,000 of group term life insurance paid by the University.
- Certain retired employees are also eligible for health expense assistance, independent of whether they were eligible to retire with standard retirement benefits (see next section).
- Lease Fee Discount. Retirees continue to receive the same discount on lease fees that they had while employed. When the retiree dies, their widow/ widowers continue to receive the discount as long as they do not remarry.
- Access to Facilities and Public Events. Retirees continue to access facilities such as duPont Library, the Fowler Center, the golf course, and tennis courts, and to attend public events such as athletic and concert series, under the same terms and fees as employees.

RETIREMENT PLANS (continued)

Contributions for Post-Retirement Health Expenses

Certain retired employees are also eligible for health expense assistance, independent of whether they were eligible to retire with standard retirement benefits.

Retirees who are 65 and older are not eligible to participate in the University Health Plan. However, the University has established certain benefits to assist eligible retirees with health expenses after age 65, through contributions to VEBA funds in Emeriti health accounts, which may be used to offset the cost of retiree medical expenses. The Emeriti program combines tax-advantaged savings with access to group retiree health insurance.

For those employed by the University and aged at least 50 as of July 1, 1995, the University contributes $1,461.60 annually to the Emeriti account. Their spouses who were also on the University's health plan at the time of retirement also receive this amount annually.

For employees who were employed by the University before July 1, 1995, who have reached the age of 40, and have 5 years of service, the University contributes $600 annually to the Emeriti account. In addition, the University will pay $994 annually to the retiree after the sixth year of retirement. (Health care costs in the first five years can be paid with Emeriti funds.) Their spouses who were also on the University's health plan at the time of retirement also receive $994 annually.

For employees who were employed by the University after July 1, 1995, who have reached the age of 40, and have 5 years of service, the University contributes $600 annually to the Emeriti account. These contributions continue until the University has made 25 years of contributions or the employee retires, whichever comes first.

Financial Advising Program

The University has partnered with CAPTRUST to offer complimentary, individual financial advising to all of our employees. While this service's primary goal is to assist you and your family with retirement planning (including investment advising), you are also welcome to discuss any outside investments, household budgeting, debt reduction, etc. and include family members in your advising session as you are comfortable.

You are encouraged to schedule an appointment with one of CAPTRUST's Certified Financial Advisors, either telephonically via their call center or in-person via our institution's dedicated advisor. Scheduling contact information is located at the University's Office of Human Resources site at hr.sewanee.edu, under the Benefits Information section.

ADDITIONAL BENEFITS

The University of the South offers you and your family additional benefits to enhance your benefits package.

Employee Assistance Program

Sometimes life can be challenging. That's why Sewanee provides an employee assistance program (EAP) to all eligible employees—at no cost to you. The EAP is designed to provide prompt, confidential help with a range of personal and family issues that may affect all of us from time to time. Your ComPsych Guidance Resources program offered through Sun Life provides someone to talk to and resources whenever and wherever you need them.

Through the EAPBusiness Class Anytime you have access to:

- Confidential Emotional Support
- Work-Life Solutions
- Legal Guidance
- Financial Resources
- Online Support
- Help for New Parents
- Free Online Will Preparation

Contact EAPBusiness Class Anytime!
No-cost, confidential solutions to life's challenges

Call: 877.595.5281

TDD: 800.697.0353

Online: guidanceresources.com

App: GuidanceResources® Now

Web ID: EAPBusiness

ProtectMyID - a service offered through BlueCross BlueShield

If you're enrolled in the medical plan you have access to Identity Protection! BlueCross BlueShield of Tennessee has partnered with Experian, one of the world's leading financial services companies, to provide the following identity protection services as part of our medical plans at no additional cost to you:

- ProtectMyID provides credit monitoring, fraud protection and fraud resolution support to adults with eligible BlueCross medical coverage. Each covered member age 18 or older will need to enroll separately.
- FamilySecure provides credit monitoring for all covered children under age 18 in the household.

To Enroll:

You can enroll by calling Experian at 1-866-926-9803. Enter Activation Code **7V8X7W3WX** for ProtectMyID or Activation Code **CSW9VPNBZ** for FamilySecure. Please visit **bcbst.com/ProtectMyID** for additional details.

Emergency Travel Assistance & Identity Theft Protection

Emergency Travel Assistance & Identity Theft Protection are extra services included as part of your life insurance through Sun Life. Below is more information:

Emergency Travel Assistance: If you or your family member have a medical emergency while you are more than 100 miles away from home, you have have the resources to help through Assist America. With one phone call, you have access to pre-qualified, English-speaking professionals working in hospitals, pharmacies, and dental offices. medical consultation, hospital admission assistance, prescription assistance, transportation to return home and much more. Contact information is below:

1-800-872-1414 (Within the US)
1-609-986-1234 (Outside the US)
01-AA-SUL-100101- Membership number

Identity Theft Protection: If you ever become a victim of identity theft, you have support of a Identity Theft Protection program. It provides:

- 24/7 telephone support and step-by-step guidance by anti-fraud experts.
- A case worker assigned to you to help you notify the credit bureaus and file paperwork to correct your credit reports.
- Help canceling stolen cards and reissuing new cards.
- Help notifying financial institutions and government agencies. Below is the contact information: 1-877-409-9597
- **www.securassist.com/sunlife**. 18327 (access code)

GLOSSARY

Understand the medical terms that are used in your plan.

Brand Name Drugs: Drugs that have trade names and are protected by patents. Brand name drugs are generally the most costly choice.

Coinsurance: The percentage of a covered charge paid by the plan.

Consumer Driven Health Plan (CDHP): A medical plan used in conjunction with a Health Reimbursement Account (HRA) or a Health Savings Account (HSA).

Copayment (Copay): A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

Deductible: The annual amount you and your family must pay each year before the plan pays benefits.

Flexible Spending Account (FSA): An FSA allows you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.

Generic Drugs: Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

In-Network: Use of a health care provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

Out-of-Network: Use of a health care provider that does not participate in a plan's network.

Mail Order Pharmacy: Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Inpatient: Services provided to an individual during an overnight hospital stay.

Outpatient: Services provided to an individual at a hospital facility without an overnight hospital stay.

Out-of-Pocket Maximum: The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year, except for prescriptions under all medical plans except the HSA Plan.

Primary Care Physician (PCP): Physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists as necessary.

Specialist: A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).

CONTACTS

PLAN	PROVIDER	PHONE NUMBERS	WEBSITE	POLICY NUMBER
Medical	BlueCross BlueShield of Tennessee	800-565-9140	www.bcbst.com	92050
Telemedicine	PhysicianNow through BCBST	1-888-283-6691	www.bcbst.com/member (click on Managing Your Health and select PhysicianNow)	92050
Dental	BlueCross BlueShield of Tennessee	800-565-9140	www.bcbst.com	92050
Vision	Vision Service Plan	800-877-7195	www.vsp.com	30023090
Medical & Dependent Care Spending Accounts	TASC	800-422-4661	www.tasconline.com	4902-2535-4441
Life & AD&D Insurance	Sun Life	800-247-6875	www.sunlife.com	918032
Long-Term Disability	Sun Life	800-247-6875	www.sunlife.com	918032
Employee Assistance Program (EAP)	ComPsych	877-595-5281	www.guidanceresources.com	N/A
403(b) Retirement Savings Plan	TIAA	800-842-2252	https://www.tiaa.org/sewanee	150348
Financial Advising Program	CAPTRUST	800-967-9948	https://www.captrustadvice.com /schedule-an-appointment/	N/A

ANNUAL NOTICES

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 The University of the South Health Plan 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. The University of the South has determined that the prescription drug coverage offered by The University of the South's Health 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 The University of the South coverage will not be affected. An explanation of The University of the South prescription drug coverage plan provisions and options is available in the Evidence of Coverage booklet. Should you need an additional copy, please see your local Human Resource representative. If you do decide to join a Medicare drug plan and drop your current The University of the South coverage, be aware that you and your dependents will 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 The University of the South 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 Resources Office for further 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 The University of the South 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:	10/7/2019
Name of Entity/Sender:	University of the South
Contact--Position/Office:	Human Resources
Address:	735 University Avenue Sewanee, TN 37383
Phone Number:	931-598-1230

Women's Health and Cancer Rights Act Notices

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply.
If you would like more information on WHCRA benefits, call Human Resources at 931-598-1230.

Notice of Availability University of the South Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

Blue Cross Blue Shield of Tennessee (the "Plan") provides health benefits to eligible employees of University of the South (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact Chris Champion, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach him at: 931-598-1230.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself 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 or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances: Visit www.medicare.gov

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60 day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30 day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Chris Champion at 931-598-1230.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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 July 31, 2019. Contact your State for more information on eligibility:

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid

Website:
http://dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid

Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

PENNSYLVANIA – Medicaid

Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

General Notice of COBRA Continuation Coverage Rights
** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to The University of the South and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment; Death of the employee;

- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Chris Champion and include documentation of loss of coverage.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Chris Champion, Benefits Administrator, 735 University Avenue, Sewanee, TN 37383 931-598-1213 or cbchampi@sewanee.edu

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

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

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact Maris Owens at 931-598-123.

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

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name University of the South			4. Employer Identification Number (EIN) 62-0475697
5. Employer address 735 University Avenue			6. Employer phone number 931-598-1213
7. City Sewanee	8. State TN	9. ZIP code 37383	
10. Who can we contact about employee health coverage at this job? Chris Champion- Benefits Administrator			
11. Phone number (if different from above) 931-598-1213	12. Email address cbchampi@sewanee.edu		

Here is some basic information about health coverage offered by this employer:
As your employer, we offer a health plan to:

- All employees. Eligible employees are:

  ☐

- Some employees. Eligible employees are:

  ☑

  - Full-time regular employees, including tenure track and tenured faculty
  - Term staff and contingent faculty with full-time appointments for more than 24 consecutive months who continue to work at least half-time after the 24th month
  - Part-time regular staff who are scheduled to work at least 3/4 time (1560 hours annually for non-exempt employees)

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  - Children under 26 years of age
  - Spouses or partners of eligible employees

  ☐ We do not offer coverage.

  If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

  If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

SUMMARY OF BENEFITS AND COVERAGE (SBC)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $750 person/$2,250 family Out-of-network: $1,875 person/$5,625 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, Office visits, Prescriptions drugs, and Emergency room visits are covered before you meet your deductible (unless specified).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $4,000 person/$8,000 family Out-of-network: $10,000 person/$20,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billing charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. This plan uses Network P. See www.bcbst.com/NetPP or call 1-800-565-9140 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office copay.
	Specialist visit	$45 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office copay.
	Preventive care/screening/ immunization	No Charge	40% coinsurance	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% coinsurance	Not subject to the deductible.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbst.com/rxp	Generic drugs	$15 copay/prescription deductible does not apply.	40% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. 2 times Retail Copayment up to 90 day supply.
	Preferred brand drugs	$40 copay/prescription deductible does not apply.	40% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. 2 times Retail Copayment up to 90 day supply. When a brand drug is chosen and a generic drug equivalent is available, you will pay a penalty for the difference between the cost of the brand drug and the generic drug, plus the generic drug copayment or coinsurance.
	Non-preferred brand drugs	$65 copay/prescription deductible does not apply.	40% coinsurance	
	Specialty drugs	$130 copay/prescription deductible does not apply.	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Preferred Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	Emergency room care	$150 copay/visit deductible does not apply.	$150 copay/visit deductible does not apply.	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$45 copay deductible does not apply.	40% coinsurance	Office surgery subject to office copay.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient servsices	$25 copay/visit deductible does not apply for office visits and 20% coinsurance other outpatient services	40% coinsurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Inpatient services	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Office visits	$25 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office copay.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.
If you need help recovering or have other special health needs	Home health care	No Charge	40% coinsurance	100% not subject to deductible. Unlimited visits per year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Therapy limited to 30 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Habilitation services	20% coinsurance	40% coinsurance	Therapy limited to 30 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing and rehabilitation facility limited to 100 days combined per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 50% if not obtained.
	Hospice services	No Charge	40% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids for adults
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care for non-diabetics
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Hearing aids for children under 18
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or www.bcbst.com, or contact your plan administrator.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- BlueCross at 1-800-565-9140 or www.bcbst.com, or your plan administrator.
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- The State Division of Benefits Administration at 1-866-576-0029.

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Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
• The plan's overall deductible	$750
• Specialist copay	$45
• Hospital (facility) coinsurance	20%
• Other coinsurance	20%
This EXAMPLE event include services like: Specialist office visits (*prenatal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (*ultrasounds and blood work)* Specialist visit *(anesthesia)*	
Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$40
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,050**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
• The plan's overall deductible	$750
• Specialist copay	$45
• Hospital (facility) coinsurance	20%
• Other coinsurance	20%
This EXAMPLE event includes services like: Primary care physician office visits (*including disease education)* Diagnostic tests *(blood work)* Prescription drugs Durable medical equipment *(glucose meter)*	
Total Example Cost	**$7,400**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$60
Copayments	$2,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$2,110**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
• The plan's overall deductible	$750
• Specialist copay	$45
• Hospital (facility) coinsurance	20%
• Other coinsurance	20%
This EXAMPLE event includes services like: Emergency room care *(including medical supplies)* Diagnostic test *(x-ray)* Durable medical equipment *(crutches)* Rehabilitation services *(physical therapy)*	
Total Example Cost	**$1,900**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$500
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,310**

Nondiscrimination Notice

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,000 person/$6,000 family Out-of-network: $4,000 person/$12,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, Office visits, Prescriptions drugs, and Emergency room visits are covered before you meet your deductible (unless specified).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $5,500 person/$11,000 family Out-of-network: $11,000 person/$22,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billing charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. This plan uses Network P. See www.bcbst.com/NetPP or call 1-800-565-9140 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office copay.
	Specialist visit	$50 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office copay.
	Preventive care/screening/ immunization	No Charge	40% coinsurance	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% coinsurance	Not subject to the deductible.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbst.com/rxp	Generic drugs	$15 copay/prescription deductible does not apply.	40% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. 2 times Retail Copayment up to 90 day supply.
	Preferred brand drugs	$50 copay/prescription deductible does not apply.	40% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. 2 times Retail Copayment up to 90 day supply. When a brand drug is chosen and a generic drug equivalent is available, you will pay a penalty for the difference between the cost of the brand drug and the generic drug, plus the generic drug copayment or coinsurance.
	Non-preferred brand drugs	$75 copay/prescription deductible does not apply.	40% coinsurance	
	Specialty drugs	$150 copay/prescription deductible does not apply.	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Preferred Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	Emergency room care	$250 copay/visit deductible does not apply.	$250 copay/visit deductible does not apply.	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay deductible does not apply.	40% coinsurance	Office surgery subject to office copay.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit deductible does not apply for office visits and 20% coinsurance other outpatient services	40% coinsurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Inpatient services	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Office visits	$30 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office copay.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.
If you need help recovering or have other special health needs	Home health care	No Charge	40% coinsurance	100% not subject to deductible. Unlimited visits per year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Therapy limited to 30 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Habilitation services	20% coinsurance	40% coinsurance	Therapy limited to 30 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing and rehabilitation facility limited to 100 days combined per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 50% if not obtained.
	Hospice services	No Charge	40% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids for adults
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care for non-diabetics
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Hearing aids for children under 18
- Non-emergency care when traveling outside the U.S.

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- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
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Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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• Other coinsurance	20%
This EXAMPLE event include services like: Specialist office visits (*prenatal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (*ultrasounds and blood work)* Specialist visit *(anesthesia)*	
Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$40
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,000

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
• The plan's overall deductible	$2,000
• Specialist copay	$50
• Hospital (facility) coinsurance	20%
• Other coinsurance	20%
This EXAMPLE event includes services like: Primary care physician office visits (*including disease education)* Diagnostic tests *(blood work)* Prescription drugs Durable medical equipment *(glucose meter)*	
Total Example Cost	**$7,400**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$60
Copayments	$2,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	$2,410

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
• The plan's overall deductible	$2,000
• Specialist copay	$50
• Hospital (facility) coinsurance	20%
• Other coinsurance	20%
This EXAMPLE event includes services like: Emergency room care *(including medical supplies)* Diagnostic test *(x-ray)* Durable medical equipment *(crutches)* Rehabilitation services *(physical therapy)*	
Total Example Cost	**$1,900**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,700

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SEWANEE
THE UNIVERSITY OF THE SOUTH

About This Guide

This benefit summary provides selected highlights of The University of the South employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the Company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. The University of the South reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.