ENROLLMENT BROCHURE

HEALTH AND VISION CARE
DENTAL CARE
FLEXIBLE SPENDING ACCOUNTS
HEARING DISCOUNTS

2012

ENROLLING IN YOUR 2012 BENEFITS

This enrollment brochure is designed to provide you with important information about your University of Dayton benefits program for 2012, including your health care plan options, your dental plan, and information about flexible spending accounts.

Included in this brochure is:

- Information about your 2012healthcare plan options,
- Information explaining your EyeMed vision plan,
- Superior Dental Care information,
- Flexible Spending Account information,
- Information regarding your Avada hearing discount program
- Instructions on how to enroll for benefits coverage.

Remember, your payroll deductions can be made on a pre-tax basis. This means that:

- The cost for your health care and/or dental coverage is deducted from your paycheck before you pay any federal, state or Social Security taxes.
- This deduction reduces your taxable income – the amount on which you pay taxes.
- Reduced income taxes mean you have more take-home pay than you would have had if premiums were deducted after taxes.

Enrollment Period

In order to participate in the University's medical, dental and/or flexible spending accounts for 2012, you must return your enrollment forms for the appropriate plan/s within 30 days of the day that you first become eligible for benefits.

In This Issue …

YOUR 2012 HEALTH CARE PLANS

Quality health care coverage for our employees is a priority at the University of Dayton. This commitment to providing quality coverage is balanced by our concern for maintaining costs at a reasonable level. We have worked hard to ensure that both of these priorities are met.

Your Health Care Plan Options

The University provides you with the choice and flexibility to choose a health care plan that best meets the needs of you and your family. That's why we are offering two Anthem plans, Core and Advantage, for you to choose from.

How Your Health Care Plan Options Work

Both health care plan options are Preferred Provider Organizations (or PPOs). The Core and Advantage plans differ in the amount of coverage they provide.

Here's how they work:

- You may choose to receive care from any qualified provider, but the plan pays a higher level of coverage if you use network doctors or hospitals. That's because network doctors and hospitals have agreed to charge discounted fees in return for the plan's participants using their services.
- You can use providers who are not in the plan's network, but you pay a deductible and your share of the expenses is greater because providers outside the network have not agreed to charge discounted fees.

Provider Directories/Preferred Prescription Drug Formulary List

To access the most up-to-date network and formulary information, check out Anthem's on-line directory at www.anthem.com and click on the *Blue Access PPO* network. Detailed instructions on how to navigate the Anthem website, can be accessed through the Human Resources website at http://community.udayton.edu/finadmin/hr/ in the Benefits section. Also, you may call Anthem directly at (800) 552-9159 with any questions.

An online calculator is available on the HR website in the Benefits section to assist you in determining which plan works better for you and your family.

In accordance with the Patient Protection & Affordability Care Act, married or unmarried children that are the natural, adopted or stepchild of you or your spouse can be covered under the University of Dayton medical plan to his/her 26th birthday. The University of Dayton will extend this coverage through the end of the calendar year in which the adult child reaches age 26. Additionally, the University has also elected to extend the same eligibility for the dental and vision plans. Please note that in order to be covered, an adult child must not be eligible for other employer sponsored coverage.

√ Helpful Tip #1 – How to choose a health care plan

What's more important to you: lower out-of-pocket costs when you use the plan, or lower payroll deductions?

- If your use of the health care plan is low and lower payroll deductions are what you're looking for, then consider the Core plan. This option offers lower payroll deductions, but you'll pay a greater portion of the charges each time you receive care. Especially with this option, you should consider enrolling in a Health Care Flexible Spending Account to pay these costs with pre-tax dollars.
- If you and your family use the health care plan often and lower out-of-pocket costs at the time of service are important, then take a look at the Advantage plan. You pay more in monthly payroll deductions, but your cost for service each time you need care is lower.
- One suggestion to help you choose the best plan for you is to estimate next year's expenses based on the past year's usage and calculate your out-of-pocket costs under each plan. Use the online calculator mentioned above to help you determine which plan works best for you and your family. (***Please note your best plan choice will vary depending on projected usage and costs)***

The following pages contain a detailed look at the services covered and the percentage that the **plan pays** depending on the health care plan and provider (in or out of network) you choose.

YOUR 2012 HEALTHCARE PLAN OPTIONS

	Anthem Core Plan		Anthem Advantage Plan	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	• $500/person • $1,000/family	• $1,000/person • $2,000/family	• $100/person • $200/family	• $500/person • $1,000/family
Out-of-pocket limit [1]	• $3,000/person • $6,000/family	• $6,000/person • $12,000/family	• $2,000/person • $4,000/family	• $4,000/person • $8,000/family
Office visit encounter	• 100% after $25 co-pay for PCP* • 100% after $50 co-pay for Specialist	60% after deductible	• 100% after $20 co-pay for PCP* • 100% after $40 co-pay for Specialist	70% after deductible
Routine physical exam/ immunizations (1 per 12 mos.)	• 100% after $25 co-pay for PCP* • 100% after $50 co-pay for Specialist	60% after deductible	• 100% after $20 co-pay for PCP* • 100% after $40 co-pay for Specialist	70% after deductible
Well baby care (6 visits first yr of life; 1 visit/yr up to age 6)	100% after $25 co-pay	60% after deductible	100% after $20 co-pay	70% after deductible
Routine gynecological exam (1 per 12 mos.)	100% after $25 co-pay	60% after deductible	100% after $20 co-pay	70% after deductible
Routine cancer screening (mammograms, PSA tests and an occult blood stool test)	• 100% after $25 co-pay if seen by a PCP* • 100% after $50 co-pay if seen by a Specialist	60% after deductible	• 100% after $20 co-pay if seen by a PCP • 100% after $40 co-pay if seen by a Specialist	70% after deductible
Routine eye & hearing exams (1 per 12 mos.)	100% after $50 co-pay	60% after deductible	100% after $40 co-pay	70% after deductible
Surgery (including oral surgery due to an accident)	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Physician in-hospital services	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Allergy testing	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Allergy Shots*	100% after $5 co-pay **-or –** $25 co-pay if seen bv PCP $50 co-pay if seen by specialist	60% after deductible	100% after $5 co-pay **–or-** $25 co-pay if seen bv PCP $50 co-pay if seen by specialist	70% after deductible
Diagnostic x-ray and lab	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Hospital- Inpatient	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Hospital- Outpatient	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Emergency Room[2] (co-pay waived if admitted)	100% after $150 co-pay	100% after $150 co-pay	100% after $150 co-pay	100% after $150 co-pay
Non-emergency use of ER [3]	No coverage			
Urgent Care	100% after $75 co-pay	100% after $75 co-pay	100% after $75 co-pay	100% after $75 co-pay
Anesthesia	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Outpatient surgery	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Chiropractic services (12 visits/yr)	100% after $50 co-pay in office	60% after deductible	100% after $40 co-pay in office	70% after deductible

	Anthem Core Plan		Anthem Advantage Plan	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Skilled nursing facility[4] (max 90 days/ calendar yr)	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Home health care (out-of-network max of 30 days per calendar yr)	80% after deductible unlimited visits	60% after deductible	90% after deductible unlimited visits	70% after deductible
Hospice (unlimited days both in and out-of-network)	80% after deductible	80% after deductible	90% after deductible	90%, after deductible
Prescription drug (Core plan deductible is per person and does not apply to Tier 1 medications.)	$50 deductible then: 30 day retail: Tier 1 $10; Tier 2 $30; Tier 3 $50 90 day mail order: Tier 1 $20; Tier 2 $75; Tier 3 $125	50% after deductible; minimum $50 Mail order is network only	30 day retail: Tier 1 $10; Tier 2 $30; Tier 3 $50 90 day mail order: Tier 1 $20; Tier 2$60; Tier 3 $100	50% after deductible; minimum $50 Mail order is network only
Ambulance	80% after deductible	80% after deductible	90% after deductible	90%, after deductible
Durable Medical Equipment	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Rehabilitation therapies[4] (physical & occupational) Max 60 visits/ calendar year	100% after $50 co-pay in office	60% after deductible	100% after $40 co-pay in office	70% after deductible
Speech therapies[4] to restore lost functions as a result of illness or injury only (max 20 visits per calendar yr)	100% after $50 co-pay in office	60% after deductible	100% after $40 co-pay in office	70% after deductible
Mental Health & Substance Abuse[5]				
Inpatient coverage	80% after deductible	60% after deductible	90% after deductible	70% after deductible
Outpatient coverage (in-network max of 30 days; out-of-network mental health max of 10 days/ calendar year)	100% after $25 co-pay/visit in office or 80% after deductible for outpatient facility	60% after deductible	100% after $20 co-pay per visit in office or 90% after deductible for outpatient facility	70% after deductible

1 All deductible, coinsurance and co-pay for ER apply to the out-of-pocket limit. Copays for Rx drugs and human organ tissue transplant (excluding kidney and cornea) and flat dollar co-pays for urgent care & office visits do not apply to the out of pocket limit..

2 Out of network charges may be subject to balance billing

3 A true emergency is defined as an "emergency condition that is evidence by sudden symptoms of disease or injury severe enough that without treatment is either life-threatening or will likely result in permanent disability."

4 Maximums (number of days, visits, etc.) are a combined limit for in-network and out-of-network services.

5 We encourage you to contact Anthem's Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations. Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health parity.

**Charges will depend upon how the service is billed by the physician's office*

**PCP= Primary Care Physicians: Include General Practitioners, Internists, Family Practitioners, Pediatricians, Obstetricians, Gynecologists, Geriatricians and mental health providers.*

Please Note:

- Pre-existing condition limitations may apply for
  - new employees and/or their dependents over the age of 18;
  - employees and/or their dependents over age 18 who didn't join the plan when first eligible but later joined during open enrollment, and
  - employees and/or their dependents over age 18 joining within 31 days of a qualified status change.

Any pre-existing condition limitation will be offset by an equal number of months of proven coverage under any U.S. health insurance plan.

- Evidence of insurability may apply to employees and/or their dependents who didn't join the plan when first eligible but later joined during open enrollment.

Review of Your Prescription Drug Plans

Your prescription drug programs give you the choice and flexibility for your doctor to prescribe the right drugs to meet your health care needs. Your Rx co-pay is based on the health care plan you choose, and the type of drug you use. The prescription drug list along with instructions to navigate Anthem's website, can be accessed through the Human Resources website at http://community.udayton.edu/finadmin/hr and clicking on Benefits. Also, you may call Anthem customer service at (800) 552-9159 or Express Scripts directly at866-216-5449.

There are Three Types of Prescription Drugs You Can Receive:

- **Tier 1 drugs**– This tier consists mainly of generic drugs which are equivalent in therapeutic power to the brand-name originals because they contain equivalent active ingredients at the same doses. ***These drugs are the least expensive.***
- **Brand-name drugs on Tier 2** – These are brand-name drugs selected by the carrier based on their quality, safety, and cost. If you use these brand-name drugs, you pay less than you would pay for other brand-name drugs. That's because the carriers have negotiated discounted rates for these drugs. These lists are comprehensive and include many commonly used drugs. (*The drug listing is available on Anthem's website as noted above and is updated periodically, so be sure to check the status of any drugs you are taking*.)
- **Brand-name drugs on Tier 3** – *These drugs tend to be the most expensive.*

Save Time and Money with Mail Order Feature available under all plans

This feature allows you to order a 90-day supply of maintenance prescription drugs by mail. Maintenance prescription drugs are those you take for more than 30 days for chronic conditions such as allergies, arthritis, diabetes, heart disease, and high blood pressure.

Mail order saves you time and money. Here's how:

- ***Convenience*** – By using the mail order feature, you can get a 90-day supply of drugs without having to make monthly trips to the pharmacy.
- ***Cost savings*** – Your cost for a 90-day supply of drugs is less than you would pay if you went to a retail pharmacy every month for three months.

Mandatory Generic Substitution

If you select a brand name medication when a generic is available, you will pay the generic co-pay plus the cost difference between the generic and brand drug. If a doctor issues a brand name prescription and writes "Dispense as written" on it, then the brand co-pay applies even if a generic is available.

√Helpful Tip #2 – How You can Save on Prescription Drug Costs

Rising drug costs affect everyone. There are three important ways to save on prescription drug costs:

- **Buy generic drugs** – You pay less for generic drugs. Generic drugs are chemically equivalent to brand-name drugs, but they generally cost 30% to 70% less. You don't give up quality, just the higher price tag. If your doctor prescribes a brand-name drug, ask if there is a generic equivalent available that is appropriate for you or ask your pharmacist to dispense the generic equivalent.
- **Take advantage of the mail order program** – If you take medication for a chronic condition such as diabetes or high blood pressure, the mail order program can save you both time and money.
- **Check for drugs on the formulary or preferred drug list** – If the drug you're ordering is not available as a generic, talk with your doctor to see if a brand-name medicine on the Tier 2 list is appropriate. This allows you to use a brand-name drug – but at a lower cost to you.

YOUR EYEMED VISION PLAN

The University offers a materials only plan through EyeMed Vision Care that will provide a benefit toward the cost of your glasses and contacts. Everyone enrolled in one of the UD healthcare plans will automatically be enrolled in the vision supplement plan. **There will be no need to enroll separately and the plan is not available to be purchased alone.** Please see the chart to the right and the brochure in the Health and Dental folder for benefits available in this plan. **You will receive a separate EyeMed ID card.** *Remember that your annual eye exam is a covered benefit under both Anthem PPO plans.*

YOUR HEARING DISCOUNT PROGRAM

This program through Avada Audiology and Hearing Care provides all benefit eligible employees and their family members with discounts on hearing instruments and free annual screenings. Please refer to the information page included in the Health & Dental folder in your Benefit Box for further information about the program.

EYEMED VISION CARE BENEFITS

	Network	Non-network
Frames	**$130 allowance; 20% off balance over $130**	**Up to $65**
Lenses:		
Single vision	**$10 Co-pay**	**Up to $25**
Bifocal	**$10 Co-Pay**	**Up to $40**
Trifocal	**$10 Co-Pay**	**Up to $55**
Contacts:		
(in lieu of lenses & frames)	**$0 Co-pay; $130 allowance; 15% off Balance (conventional)**	**$104 (conventional)**
	$0 Co-pay; $130 Allowance	**$104 (disposable)**
	$0 Co-pay- Paid in Full (medically necessary)	**$200 (medically necessary)**
Frequency:		
(lenses, frames & contacts)	**Once every 12 mos.**	**Once every 12 mos.**

2012Monthly Healthcare Premiums

	CORE	ADVANTAGE
EMPLOYEE ONLY	$33.00	$128.00
EMPLOYEE + SPOUSE	$78.00	$337.00
EMPLOYEE + CHILD(REN)	$63.00	$283.00
EMPLOYEE + SPOUSE + CHILD(REN)	$88.00	$358.00
BOTH SPOUSES UD BENEFIT ELIGIBLE (NO CHILDREN)	$0.00	$168.50
BOTH SPOUSES UD BENEFIT ELIGIBLE (WITH CHILD(REN))	$0.00	$179.00

YOUR SUPERIOR DENTAL CARE PLAN

You will receive your dental coverage through Superior Dental Care, a local dental plan company. Your coverage is highlighted in the chart below. The plan provides coverage for a wide range of services – from oral examinations and x-rays to extractions and orthodontia for children.

2012 Monthly Premium Rates	
Single	$29.77
Family	$86.23

How the Plan Works

- **No deductible** – the plan pays first dollar on claims.
- **No claim forms** – simply present your membership card at the time of service.
- **No balance billing** – you are only responsible for your coinsurance based on a percentage of the dentist's charge.
- **Orthodontic maximum** – lifetime maximum is $1,000 and is not offset by benefits paid by any previous plan.
- **SMILE*RIDER*™** is a supplemental cosmetic rider that provides a 15% discount for elective cosmetic services such as teeth whitening, veneers, bonding, and porcelain facings. SMILE*RIDER*™ dentists are identified by a (☺) in the directory of providers.
- **EyeMed Vision Care** (this is a separate discount plan included with your dental plan) provides discounts on examinations and materials at unlimited frequencies. Available at Lenscrafters® and Optique® locations as well as many optician offices (for more information please call (877) 226-1115).

Choosing Your Dentist

You must seek care from a participating dentist in order to receive the highest level of benefits. If you receive care from a non-participating dentist, you will be reimbursed directly by Superior Dental Care and you may be responsible for payment of any remaining balance. Check the Superior Dental Care website at **www.superiordental.com** to verify the participation of your dentist. You may switch dentists or self-refer to a specialist at any time.

Your Dental Plan At-A-Glance

Here's a look at the percentage the plan pays for covered services:

Preventive & Diagnostic Services – 100%
- Exams
- Cleanings
- X-rays

Basic Services – 80%
- Fillings
- Extractions
- Root Canals
- Periodontal services

Major Services – 50%
- Crowns
- Bridges
- Dentures
- Sealants
- Occlusal Guards

Annual Maximum - $1,000 per person

Orthodontia – Lifetime Maximum of $1000 (For eligible dependents to age 20)

Deductibles – none.

FLEXIBLE SPENDING ACCOUNTS – A GREAT WAY TO SAVE

GRACE PERIOD

For 2012, the year-end deadline for the ***Health Care Spending Account only*** will be extended by a 2 ½ month grace period to allow for unused funds for the 2012 plan year to be carried into 2013. You will have until March 15, 2013 to use the dollars you elect for 2012.

MyCafeteriaPlan, our administrator, will provide:

- Web-based access to account balances and claim payment status at www.mycafeteriaplan.com
- On-line claim forms
- Direct deposit of claim payments to your bank account
- Claims reimbursement every Wednesday

As always, you can save on your out-of-pocket health care (such as prescription drug and office visit co-pays) and day care expenses by taking advantage of our Health Care and/or Dependent Care Flexible Spending Accounts (FSAs). FSAs allow you to set aside money during the year that you can use to reimburse yourself for eligible expenses incurred during the year. And the best part is that this money is set aside before federal and state income or Social Security taxes are withheld, thus lowering your taxable income.

How the Accounts Work

Each year you decide whether or not you want to participate in the Health or Dependent Care FSA.

If you decide to participate:

- You estimate the amount of eligible expenses you are likely to have during the year and decide how much of your salary you want to set aside (use the FSA worksheet on Page 4 and 5 in the FSA brochure to help estimate your annual expenses). Remember, you can save up to $5,000 for the Health Care FSA and up to $5,000 ($2,500 if you are married and file separate income tax returns) for the Dependent Care FSA. The amount you elect is divided by your annual pays and automatically deducted from your paycheck each pay period.

As you incur eligible expenses during the year, you pay for them out of your own pocket, then reimburse yourself from your flexible spending account with tax-free money.

What's an Eligible Expense?

See the brochure in the FSA folder for a sample listing of eligible Health and Dependent Care FSA expenses. **Remember, over-the-counter medications are no longer eligible expenses.**

√ Helpful Tip #3 – Don't forget about these IRS restrictions

Before you decide to participate, keep in mind that the IRS imposes a number of restrictions on your FSA contributions, including:

- **One-Year Commitment** – You may not stop, start, or change the amount of money you contribute during the year unless you have a qualified status change, such as the birth of a child, adoption, or divorce. If this occurs, then your FSA change must be consistent with your status change.
- **"Use It or Lose It"** – You may only use the money in your accounts to pay for expenses you incur during the same calendar year plus the 2 ½ months allowed under the extension. Any money remaining in your account after you have applied for reimbursement for the year is forfeited and cannot be returned for any reason. You will have until April 15, 2013 to request reimbursement for expenses incurred up to March 15, 2013. This "use it or lose it" rule makes it very important that you estimate carefully before deciding to contribute.
- **No Transfers** – You may not transfer money from one account to the other. For example, you cannot use money from the Health Care FSA to pay for Dependent Care FSA expenses.

2012 MAXIMUM CONTRIBUTIONS

- HEALTH CARE SPENDING ACCOUNT $5,000
- DEPENDENT CARE SPENDING ACCOUNT $5,000

WHAT YOU NEED TO DO

Here's a quick overview of what you need to do:

- **Review the Health Care Premium Rates.** Page 8 outlines your monthly premium contributions for each plan.

  If you want to enroll in any of the coverage options, you must complete an enrollment/change form and return it to the Office of Human Resources **within 30 days of the date you first become eligible for benefits.**

  Enrollment/change forms are in the Health and Dental folder and are also available under the Forms tab at the Human Resources website at http://community.udayton.edu/finadmin/hr/.

- **If you want to waive health care and/or dental coverage, you must complete the appropriate waiver form and submit it to the Office of Human Resources within 30 days of the date you first become eligible for benefits.** Waiver forms are included in the Health and Dental folder or on the Human Resources website listed above.

- **If you want to participate in one or both of the FSAs, you must complete the Health Care Spending Account and/or Dependent Care Spending Account Enrollment Form included in the Flexible Spending Account folder and return it within 30 days of the date you first become eligible for benefits.** Forms are included in the FSA folder or are available on the HR website.

For those active employees and/or their dependents who are Medicare eligible, please note that the prescription drug coverage provided under the UD plans is creditable.

Questions?

If you have any questions about your coverage, please contact the Office of Human Resources at (937) 229-2541. You may also contact the plan administrators directly by calling Anthem at (800) 552-9159, Superior Dental Care at (937) 438-0283 or (800) 762-3159 or EyeMed Vision Care at 866-299-1358.

You will receive ID cards within approximately 2 weeks of enrolling in the coverage.

Your COBRA rights are explained in your certificate of coverage which is available on Anthem's website at www.anthem.com.

About This Enrollment Brochure

This enrollment brochure includes only highlights of employee benefits available through the University of Dayton benefits program. If any inconsistency exists between this enrollment brochure and the plan documents, the provisions of the plan documents will prevail. While the University intends to continue offering the benefits program, the University reserves the right to change, amend, or terminate the program or any of its plans at any time.