We recognize the important role employee benefits play as a critical component of overall compensation. As such, we continue to make every effort to target the best quality benefit plans for our staff and their families.

Once again it is Open Enrollment season, which is the annual period when our insurance carriers issue new rates and allow changes to be made in the plan designs and employee elections. After an extensive analysis of the renewal and plan options, Wagner College is excited to add a High Deductible Health plan to our medical plan options. You will have the opportunity to choose from 3 UMR Medical plans effective January 1, 2023.

Your medical plan options are as follows:
- UMR PPO $0 Deductible Plan
- UMR EPO Plan
- UMR High Deductible Health Plan (HDHP) EPO  New!

Cigna will continue as our Dental insurance carrier with the same 2 plan options and no increase to contributions. VSP will continue as our Vision insurance carrier.

The benefit elections you make during the Open Enrollment period will remain in effect January 1, 2023 through December 31, 2023. You will not be able to change your elections during the plan year unless you experience a qualified change in status as defined by federal law. It is important to make choices that are best for you and your family.

If you have any questions, do not hesitate to contact Human Resources or your dedicated BenefitsVIP Team.
Help Starts Here
BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefits advocates is ready to help you and your family members resolve your benefits issues.

For service that’s confidential and responsive, contact:

**866.286.5354**
Monday - Friday
8:30am - 8:00pm (ET)
Fax: **856.996.2755**
Answers@benefitsvip.com

Questions Answered Here
COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates understand your benefit plans and are able to answer benefit questions and quickly resolve claims and eligibility issues. A majority of inquiries are resolved the same day and all calls adhere to privacy best practices.

BenefitsVIP.com

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**BENEFITSVIP.COM**
Request member assistance and order ID cards with a click.

**HEALTHDISCOVERY.ORG**
Get vital, useful and fun health insurance and wellness facts.

QUESTIONS? Call BenefitsVIP at **866.286.5354**
# Medical Benefits

## PPO $0 DEDUCTIBLE PLAN

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Individual: $0 Family: $0*</td>
<td>Individual: $3,000 Family: $9,000*</td>
</tr>
<tr>
<td><strong>Out-of-pocket Maximum</strong></td>
<td>Individual: $6,600 Family: $13,200*</td>
<td>Individual: $10,500 Family: $31,500*</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>UMR 100% / Member 0%</td>
<td>UMR 70% / Member 30%</td>
</tr>
<tr>
<td><strong>Preventive Care Physical Exams</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children (through age 18)</td>
<td>Covered 100%</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Adults (age 19 and older)</td>
<td>Covered 100%</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician office visits</td>
<td>$30 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>$50 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Outpatient facility surgery</td>
<td>$375 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Lab &amp; X-Ray</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory Tests and Basic X-Rays</td>
<td>Covered 100%</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>MRIs, MRAs, PET Scan, CT Scan</td>
<td>Covered 100%</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care</strong></td>
<td>$750 copay per admission</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance (medically necessary)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>At hospital emergency room **</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$50 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td>$30 copay per initial visit then no charge</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Office visits</td>
<td>$750 copay per admission</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Hospital services for mother/child</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>$750 copay per admission</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$30 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$30 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Gym Reimbursement Program</strong></td>
<td>$200 (must complete 50 visits per 6 months)</td>
<td>$100 (must complete 50 visits per 6 months)</td>
</tr>
<tr>
<td>Employee per 6 month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse/Domestic Partner per 6 month period</td>
<td>$100 (must complete 50 visits per 6 months)</td>
<td>$100 (must complete 50 visits per 6 months)</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>No charge</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td>$100</td>
<td>Not covered</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Pharmacy (30-day supply)</td>
<td>$15 Tier 1; $30 Tier 2; $60 Tier 3</td>
<td>$15 Tier 1; $30 Tier 2; $60 Tier 3</td>
</tr>
<tr>
<td>Mail Order (90-day supply)</td>
<td>$37.50 Tier 1; $75 Tier 2; $150 Tier 3</td>
<td>$37.50 Tier 1; $75 Tier 2; $150 Tier 3</td>
</tr>
<tr>
<td><strong>Monthly Contributions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$297.19</td>
<td></td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$618.88</td>
<td></td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$570.26</td>
<td></td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$828.88</td>
<td></td>
</tr>
</tbody>
</table>

*No family member will exceed the individual amount

**Copay may be waived if admitted

**For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.

**QUESTIONS? Call BenefitsVIP at 866.286.5354**
## EPO PLAN

### BENEFIT IN-NETWORK ONLY

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Individual:</th>
<th>Family:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$750</td>
<td>$2,250*</td>
</tr>
<tr>
<td><strong>Out-of-pocket Maximum</strong></td>
<td>$6,600</td>
<td>$13,200*</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>UMR 80% / Member 20%</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Physical Exams</strong></td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Children (through age 18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults (age 19 and older)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician office visits</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>$50 copay</td>
<td></td>
</tr>
<tr>
<td>Outpatient facility surgery</td>
<td>$500 copay then 20% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Lab &amp; X-Ray</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory Tests and Basic X-Rays</td>
<td>Office setting—No charge</td>
<td>Outpatient setting—20% after deductible</td>
</tr>
<tr>
<td>MRIs, MRAs, PET Scan, CT Scan</td>
<td>Office setting—No charge</td>
<td>Outpatient setting—20% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care</strong></td>
<td>$1,000 copay then 20% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td></td>
<td>$250 copay then 20% after deductible</td>
</tr>
<tr>
<td>Ambulance (medically necessary)</td>
<td></td>
<td>$50 copay</td>
</tr>
<tr>
<td>At hospital emergency room**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>$30 copay per initial visit then no charge (deductible waived)</td>
<td></td>
</tr>
<tr>
<td>Hospital services for mother/child</td>
<td>$1,000 copay then 20% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td>$1,000 copay then 20% after deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td>$30 copay</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gym Reimbursement Program</strong></td>
<td></td>
<td>$200 (must complete 50 visits per 6 months)</td>
</tr>
<tr>
<td>Employee per 6 month period</td>
<td></td>
<td>$100 (must complete 50 visits per 6 months)</td>
</tr>
<tr>
<td>Spouse/Domestic Partner per 6 month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td></td>
<td>20% after deductible</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Retail Pharmacy (30-day supply)</td>
<td>$15 Tier 1; $30 Tier 2; $60 Tier 3</td>
<td></td>
</tr>
<tr>
<td>Mail Order (90-day supply)</td>
<td>$37.50 Tier 1; $75 Tier 2; $150 Tier 3</td>
<td></td>
</tr>
<tr>
<td><strong>Monthly Contributions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$174.30</td>
<td></td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$378.63</td>
<td></td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$342.57</td>
<td></td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$516.86</td>
<td></td>
</tr>
</tbody>
</table>

*No family member will exceed the individual amount

**Copay may be waived if admitted

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For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.

**QUESTIONS?** Call BenefitsVIP at 866.286.5354
# HIGH DEDUCTIBLE HEALTH PLAN (HDHP) EPO

**Benefit** | **IN-NETWORK ONLY**
---|---
Annual Deductible | Individual: $2,250 Family: $4,500*
Out-of-pocket Maximum | Individual: $4,000 Family: $8,000*
Coinsurance | UMR 90% / Member 10%

## Preventive Care Physical Exams
- Children (through age 18)
- Adults (age 19 and older)

## Outpatient Care
- Primary care physician office visits
- Specialist office visits
- Outpatient facility surgery

## Outpatient Lab & X-Ray
- Laboratory Tests and Basic X-Rays
- MRIs, MRAs, PET Scan, CT Scan

## Inpatient Hospital Care
- 10% after deductible

## Emergency Care
- Ambulance (medically necessary)
- At hospital emergency room
- Urgent care

## Maternity Care
- Office visits
- Hospital services for mother/child

## Mental Health
- Inpatient
- Outpatient

## Gym Reimbursement Program
- Employee per 6 month period: $200 (must complete 50 visits per 6 months)
- Spouse/Domestic Partner per 6 month period: $100 (must complete 50 visits per 6 months)

## Durable Medical Equipment
- 10% after deductible

## Prescriptions
- Deductible
  - Retail Pharmacy (30-day supply): Subject to Medical Deductible; $15 Tier 1; $30 Tier 2; $60 Tier 3
  - Mail Order (90-day supply): $37.50 Tier 1; $75 Tier 2; $150 Tier 3

## Monthly Contributions
- Employee Only: $142.61
- Employee + Spouse: $309.79
- Employee + Children: $280.29
- Employee + Family: $422.88

*No family member will exceed the individual amount.*

---

**Locate a UMR Provider**
- Go to [www.umr.com](http://www.umr.com).
- Click on "Find a Provider."

**QUESTIONS? Call BenefitsVIP at 866.286.5354**

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
About the High Deductible Health Plan Option
You have the option to elect the new High Deductible Health Plan (HDHP) EPO through UMR. A High Deductible Health Plan is a medical plan designed to lower health care costs by encouraging its members to focus on preventive care, therefore making insurance premiums more affordable.

This plan has higher deductibles that must be met before the plan begins to pay benefits. It is designed to pay for preventive care; you pay for all other care until the deductible is reached. The HDHP is offered in tandem with a Health Savings Account (HSA).

How Does the High Deductible Health Plan Work?
This EPO plan works much like any other plan with In-Network only benefits. Preventive care services are covered 100% (not subject to the deductible). Other services are covered with a 10% coinsurance once you meet the plan’s calendar year deductible; prescription drug coverage requires a copay after you meet your deductible.

Is a High Deductible Plan Right for You?
This plan may be a good option if you expect to have low medical expenses, are looking for a tax-free way to save money for future medical expenses, or if you would like greater flexibility with the way you use your medical benefits. If a HDHP is right for you, you may spend less money per month while retaining control over which doctors you see and accumulating the funds you don’t use in an HSA.

You may also want to consult with a legal or tax advisor to see if this plan is right for you.

Health Savings Account (HSA)
To be eligible to contribute to the Health Savings Account (HSA), you must elect the HDHP. Government regulations require that these savings accounts be tied to a high-deductible health plan.

You cannot participate in the HSA if you’re covered by outside health insurance or enrolled in Medicare. (Once your Medicare coverage begins, you must stop contributing to the HSA; but, you can still use your account to pay your eligible medical expenses tax-free including Medicare premiums and other plan costs.)

How the HSA Works
Once you elect the HDHP, you’ll have the opportunity to establish an HSA. All you have to do is decide how much you want to contribute on a pre-tax basis - and complete the paperwork to open your Optum Bank account. If you choose to participate, you’ll receive a debit card to access the money in your HSA (checks are also available at a small fee). You can use your debit card to pay your medical bills directly, or you can pay qualified expenses out of your own pocket and reimburse yourself from the HSA with available funds.

If you prefer to think of your HSA as a long-term savings account, you may want to leave your funds alone - and pay current expenses out of your regular income. Your account will continue to grow tax-free, including interest or investment earnings, for future use - even after retirement.

You can use your HSA to pay medical bills - but only up to the amount that’s currently in your account. Then, as additional deposits are made, you can access those funds.

Pre-Tax Contributions to HSA
Like health care premium, FSA and 401(k) contributions, your contributions to an HSA are also deducted from your pay on a pre-tax basis - before Social Security, federal, state and local taxes are calculated.

Annual HSA Limits
You may contribute to your HSA on a pre-tax basis. The maximum annual 2023 contribution amounts are:
- Employee $3,850
- Employee + Dependent(s) $7,750

If you are age 55 or older, or turning age 55 in 2023, you can make “catchup” contributions to your HSA and put an additional $1,000 in your account anytime during the year. HSA funds are not subject to “use-it-or-lose-it” rules.

Setting Up Your HSA Account
Once your enrollment elections are transmitted from UMR to Optum Bank (after Open Enrollment ends), you’ll receive a Welcome Kit by mail with information regarding the activation of the account; the debit card will arrive separately. Employees who fail the identification process may receive an additional notification in order for the bank to verify their identification. Once the accounts are verified, they will open automatically and they have 60 days to submit anything else required from UMR.

Learn More About Your HSA At
OPTUMBANK.COM
OR CALL
866.234.8913

### Tiers

<table>
<thead>
<tr>
<th></th>
<th>2023 Federal HSA Maximum Annual Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,850</td>
</tr>
<tr>
<td>Family</td>
<td>$7,750</td>
</tr>
</tbody>
</table>

**Catch up contributions for those over age 55 is $1,000 annually.**

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.

QUESTIONS? Call BenefitsVIP at 866.286.5354

OPTUM Bank
Teladoc gives you 24/7 access to U.S. board-certified doctors, from home or on the go. Call or connect online or using the Teladoc mobile app for affordable medical care, when you need it.

Teladoc is provided for a $10 copay for employees enrolled on the EPO or PPO Plans. For those enrolled on the HDHP, the cost of the service will be $49 until the deductible is met.

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infections
- Sinus problems
- Skin problems
- And more!

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

24/7 doctor visits via phone or mobile app

Talk to a doctor anytime!!
Visit Teladoc.com
Or call 800.Teladoc

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
Claim
A request for payment that you or your health care provider submits to your health insurance company when you acquire items or services you believe are covered.

Coinsurance
The percentage of costs of a covered health care service you pay (10%, for example) after you’ve paid your deductible.

Copayment/Copay
A predetermined (flat) fee an individual pays for health care services, in addition to what the insurance covers.

Deductible
The amount you pay for covered health care services before your insurance plan starts to pay. Eligible expenses applied to the In-Network deductibles will not be applied to satisfy Out-of-Network deductibles. In addition, check your carrier certificates to confirm how your plan satisfies the family deductible.

Dependent Coverage
Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

In-Network
A doctor or facility providing care and has negotiated a contract rate with your health insurance company. You may not be balanced billed for amounts over the negotiated contract rate.

Out-of-Network
A doctor or facility providing care and does not have a contract with your health insurance company. You may be balance billed for amounts over the percentage of costs paid by the insurance company (coinsurance).

Out-of-Pocket Maximum/Limit
The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. Non-covered services or amounts over the Usual and Customary (U&C) are not applied to your out-of-pocket maximum.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Preventive Care (Preventive services)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease or other health problems.

Primary Care Physician (PCP)
A physician who directly provides or coordinates a range of health care services for a patient.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Usual and Customary Allowance
Usual and customary allowance is the amount of money that a particular health insurance company determines is the normal or acceptable range of payment for a specific health-related service or medical procedure.
# Dental Benefits

## LOW PLAN

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK - CIGNA DPPO ADVANTAGE*</th>
<th>IN-NETWORK CIGNA DPPO*</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Individual: $25&lt;br&gt;Family: $75</td>
<td>Individual: $100&lt;br&gt;Family: $300</td>
<td>Individual: $100&lt;br&gt;Family: $300</td>
</tr>
<tr>
<td><strong>Dental Benefit Maximum</strong></td>
<td></td>
<td></td>
<td>$2,500 (per covered member)&lt;br&gt;$1,500 (per eligible dependent)</td>
</tr>
<tr>
<td><strong>Diagnostic &amp; Preventive Services</strong></td>
<td>100% covered no deductible</td>
<td>70% covered no deductible</td>
<td>70% covered no deductible</td>
</tr>
<tr>
<td>Prophylaxis (Cleanings, 2 per calendar year); Oral examinations; Topical fluoride; X-rays; Bitewing; Sealants (up to age 14); Space maintainers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td>80% covered after deductible</td>
<td>50% covered after deductible</td>
<td>50% covered after deductible</td>
</tr>
<tr>
<td>Fillings; Extractions; Oral surgery; Endodontics; Periodontics; Periodontal surgery; Anesthesia; Consultations; Repairs of dentures, crowns, inlays and onlays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
<td>50% covered after deductible</td>
<td>50% covered after deductible</td>
<td>50% covered after deductible</td>
</tr>
<tr>
<td>Bridge and Dentures; Crowns, Inlays, Onlays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td>50% covered after deductible</td>
<td>50% covered after deductible</td>
<td>50% covered after deductible</td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td>50% covered no deductible</td>
<td>50% covered after deductible</td>
<td>50% covered after deductible</td>
</tr>
<tr>
<td>(Children only to age 19)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monthly Contributions</strong></td>
<td></td>
<td>$8.61</td>
<td>$28.76</td>
</tr>
<tr>
<td>Employee Only</td>
<td></td>
<td>Employee + Spouse</td>
<td>$31.32</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td></td>
<td>Employee + Family</td>
<td>$47.94</td>
</tr>
<tr>
<td><strong>No Additional Member Responsibility in excess of Coinsurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.

**Locate a Dental Provider**

- Go to [www.cigna.com](http://www.cigna.com)
- Click on **Find a Doctor, Dentist or Facility** at the top of the page
- Choose Plans through your employer or school
- Click on the **Pick** icon under **Select a Plan**
- Click on **Dental Plans**
- Select your Cigna DPPO Advantage/Cigna DPPO
- Click the **Choose** icon

**QUESTIONS? Call BenefitsVIP at 866.286.5354**
# Dental Benefits

**HIGH PLAN**

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK—CIGNA DPPO*</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Individual: $50</td>
<td>Individual: $50</td>
</tr>
<tr>
<td></td>
<td>Family: $150</td>
<td>Family: $150</td>
</tr>
<tr>
<td><strong>Dental Benefit Maximum</strong></td>
<td></td>
<td>$1,250 (per covered member)</td>
</tr>
<tr>
<td>Annual Dental Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Orthodontia Maximum</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Diagnostic &amp; Preventive Services</strong></td>
<td>80% covered no deductible</td>
<td>80% covered no deductible</td>
</tr>
<tr>
<td>Prophylaxis (Cleanings, 2 per calendar year); Oral examinations; Topical fluoride; X-rays; Bitewing; Sealants (up to age 14); Space maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td>80% covered after deductible</td>
<td>80% covered after deductible</td>
</tr>
<tr>
<td>Fillings; Extractions; Oral surgery; Endodontics; Periodontics; Periodontal surgery; Anesthesia; Consultations; Repairs of dentures, crowns, inlays and onlays</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
<td>50% covered after deductible</td>
<td>50% covered after deductible</td>
</tr>
<tr>
<td>Bridge and Dentures; Crowns, Inlays, Onlays</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td>50% covered after deductible</td>
<td>50% covered after deductible</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Monthly Contributions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$47.51</td>
<td></td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$112.53</td>
<td></td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$117.22</td>
<td></td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$130.96</td>
<td></td>
</tr>
</tbody>
</table>

*No Additional Member Responsibility in excess of Coinsurance

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.

**Locate a Dental Provider**

- Go to [www.cigna.com](http://www.cigna.com)
- Click on [Find a Doctor, Dentist or Facility](http://www.cigna.com) at the top of the page
- Choose [Plans through your employer or school](http://www.cigna.com)
- Click on the [Pick](http://www.cigna.com) icon under [Select a Plan](http://www.cigna.com)
- Click on [Dental Plans](http://www.cigna.com)
- Select your Cigna DPPO Advantage/Cigna DPPO
- Click the [Choose](http://www.cigna.com) icon

**QUESTIONS?** Call BenefitsVIP at [866.286.5354](tel:866.286.5354)
# Vision Benefits

## VISION PLAN

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>$10</td>
<td>Up to $45</td>
</tr>
<tr>
<td>Materials (Frames and Lenses)</td>
<td>$25</td>
<td>Up to $70</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>12 Months*</td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td>12 Months*</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>24 Months**</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>$150 allowance</td>
<td>Up to $70</td>
</tr>
<tr>
<td></td>
<td>20% savings on amount over allowance</td>
<td></td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>Covered in Full after copay</td>
<td>Up to $30 allowance</td>
</tr>
<tr>
<td>Bifocal Vision Lenses</td>
<td>Covered in Full after copay</td>
<td>Up to $50 allowance</td>
</tr>
<tr>
<td>Trifocal Vision Lenses</td>
<td>Covered in Full after copay</td>
<td>Up to $65 allowance</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong> (in lieu of glasses)</td>
<td>Up to $150 after copay</td>
<td>Up to $105 allowance</td>
</tr>
</tbody>
</table>

**Monthly Contributions**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$12.26</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$19.61</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$20.02</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$32.27</td>
</tr>
</tbody>
</table>

*This benefit resets every calendar year

**This benefit resets every other calendar year

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.

**Locate a VSP Doctor**

- Go to [www.vsp.com](http://www.vsp.com)
- Select the Members link
- Click on Find a Doctor
- Enter the Zip Code or Address
- Select the Doctor Network
- Click Search

**QUESTIONS? Call BenefitsVIP at 866.286.5354**
Flexible Spending Accounts

Employees may deduct pre-tax monies from their paychecks to set up:

- A Healthcare FSA for eligible medical, dental or vision expenses not paid for by health insurance.
- A Dependent Care FSA to cover childcare expenses for children up to age 13 or other eligible dependents.
- A Limited Purpose FSA for employees who participate in the HDHP with HSA.

For a list of eligible FSA items visit the Isolved Benefit Services website www.isolvedbenefitservices.com. The maximum employee contributions to an FSA for 2023 is $3,050 for Healthcare, Limited Purpose FSA and $5,000 for Dependent Care. The IRS requires that any participant wishing to enroll or re-enroll in these plans actively enroll each plan year.

The Healthcare FSA (only) allows you to roll over up to $610 of unused funds at the end of one plan year into the new plan year. Any funds over $610 that remain in your account at the end of the plan year are, by federal law, forfeited. We strongly urge that all participants carefully estimate how much to elect, annually. Unless you experience a life event, you cannot change your elections in the middle of a plan year nor can you transfer funds between accounts.

<table>
<thead>
<tr>
<th>ACCOUNT TYPE</th>
<th>EXAMPLES OF ELIGIBLE EXPENSES</th>
<th>CONTRIBUTION LIMITS</th>
<th>ACCESS TO FUNDS</th>
<th>PRE-TAX BENEFIT</th>
</tr>
</thead>
</table>
| HEALTH CARE FSA | • Medical Plan Deductibles  
• Prescription Drugs  
• Some OTC medicines  
• Vision Exams/Glasses/Contacts  
• Laser Eye Surgery | There is no minimum contribution per year  
Maximum contribution is $3,050 for the 2023 plan year | Allows immediate access to the entire contribution amount from the 1st day of the benefit year, before all scheduled contributions have been made | • Save 20% - 40% on your health care expenses  
• Save on eligible purchases not covered by insurance  
• Reduce your taxable income |
| LIMTED PURPOSE FSA (for employees enrolled in the HDHP who contribute to the HSA) | Only Dental and Vision Expenses are eligible for reimbursement  
• Dental and orthodontia  
• Vision Exams/Eyeglasses/Contacts  
• Laser Eye Surgery | Employees enrolled in the HDHP/HSA may also contribute money to their Limited Purpose FSA  
Maximum contribution is $3,050 for the 2023 plan year | Allows immediate access to the entire election amount from the 1st payday of the plan year before all scheduled contributions have been made | |
| DEPENDENT CARE FSA | • Daycare  
• Day Camp  
• Eldercares  
• Before and After School Care | There is no minimum contribution per year  
Maximum contribution is $5,000 for the 2023 plan year | You will be able to submit claims up to your year-to-date accumulated amount in your account  
(You will only be reimbursed based on your accumulated contribution amounts) | |

Most over-the-counter drugs require a doctor’s prescription in order to be reimbursed from your account.

Employees may be required to provide substantiation to complete the processing of your claim and are responsible to check their balances.

Commuter Benefit Plan

The Transit and Parking program provided through ISolved allows you to contribute pre-tax dollars each month for public transit and/or parking via payroll deductions. Your annual savings will vary based on your tax rate. It is important to note that your pre-tax deduction is limited to the amount you spend on parking or public transit to commute to work. Your pre-tax deductions for parking and/or transit cannot exceed $300 per month.

Once you complete the ISolved Commuter Employee Enrollment Form and return it to Human Resources, you will receive your monthly metro card or one-time visa check card from the Human Resources team.

<table>
<thead>
<tr>
<th>ACCOUNT TYPE</th>
<th>ELIGIBLE EXPENSES</th>
<th>MONTHLY CONTRIBUTION LIMITS</th>
</tr>
</thead>
</table>
| Transit Account | • Train, bus and subway passes (Metrocards).  
• Uber/Lyft ride sharing. | Between $10 and $300 on a pre-tax basis. |
| Parking Account | • Parking at or near your work location or mass transit (used for commuting). | Between $10 and $300 on a pre-tax basis. |

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
### Basic Life Insurance
- Basic Life Insurance coverage provides important supplemental financial protection for your family in the event of your death.
- Wagner College provides eligible full-time employees with Basic Life Insurance at no cost to you.
- The Life Insurance benefit is equal to 2 times your annual salary with a maximum of $500,000.

### Accidental Death & Dismemberment (AD&D) Insurance
- AD&D Insurance coverage provides important financial protection in the event of death, loss of hands, feet and/or vision when an employee experiences a loss within 365 days of a related accident.
- All eligible full-time employees can qualify for the AD&D benefit which is equal to 2 times your annual salary with a maximum of $500,000.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>LIFE AND AD&amp;D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who’s Eligible?</td>
<td>All eligible employees</td>
</tr>
<tr>
<td>Life Benefit Amount</td>
<td>2x annual salary $500,000</td>
</tr>
<tr>
<td>AD&amp;D Benefit Amount</td>
<td>2x annual salary $500,000</td>
</tr>
<tr>
<td>Accelerated Life Benefit</td>
<td>75% of benefit amount</td>
</tr>
<tr>
<td>Seatbelt(s) Benefit</td>
<td>10% of benefit amount</td>
</tr>
<tr>
<td>Air Bag Benefit</td>
<td>5% of benefit amount</td>
</tr>
<tr>
<td>Portability</td>
<td>Included</td>
</tr>
<tr>
<td>Conversion</td>
<td>Included</td>
</tr>
</tbody>
</table>

### Glossary
- **Life Benefit**: A policy that pays a beneficiary a specified death benefit amount when the insured dies.
- **AD&D Benefit**: This is paid, in addition to the life benefit, if you die in a covered accident. It also pays if you suffer a covered dismemberment.
- **Accelerated Life Benefit**: If you become terminally ill with less than 12 months to live, you have access to part of your life benefit early, up to your plan’s maximum. Applies to active employees only.
- **Seatbelt(s) Benefit**: Pays an additional benefit if you die in a covered private-passenger car accident while wearing a seat belt.
- **Air Bag Benefit**: An extra benefit is paid if the seat is protected by an airbag plus seat belt and your seat belt is properly fastened.
- **Portability**: The eligible employee can continue term life coverage after a qualifying event at specified rates.
- **Conversion**: All or some of your term insurance is converted into a permanent life insurance policy.

### New York State Disability (NYS DBL)
- NYS DBL coverage provides important financial protection for your family in the event of an extended recovery from accident or illness.
- All eligible employees can qualify to receive NYS DBL coverage.
- The NYS DBL benefit is calculated at 50% of your weekly salary to a maximum of $170 weekly, with a 26-week maximum period of payment.
- The elimination period is 7 days for disability due to injury and 7 days for disability due to sickness.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>NYDBL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Amount</td>
<td>50% of weekly earnings</td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td>$170 per week</td>
</tr>
<tr>
<td>Benefit Duration</td>
<td>Up to 26 weeks</td>
</tr>
<tr>
<td>When Benefits Begin</td>
<td>After 7 days of sickness or injury</td>
</tr>
</tbody>
</table>

### Paid Family Leave
NY Paid Family Leave will provide paid time off for employees to:
- Bond with a newly born, adopted, or fostered child.
- Care for a family member with a serious health condition.
- Assist loved ones when a family member is deployed abroad on active military duty.

### Eligibility
Employees with a regular work schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment. Employees with a regular work schedule of less than 20 hours per week are eligible after 175 days worked.

### Important
You cannot collect disability benefits and paid family leave benefits at the same time. The total combined disability leave and paid family leave in any 52 week period may not exceed 26 weeks.
Supplemental Short Term Disability

- Short Term Disability coverage provides important financial protection for your family in the event of an extended recovery from accident or illness.
- All eligible full-time employees can qualify to receive Short Term Disability coverage.
- The Short Term Disability benefit is calculated at 66.67% of your weekly salary to a maximum of $2,000 weekly, with a 26-week maximum period of payment.
- Your Short Term Disability benefit will be offset by the amount you receive from NYS DBL.
- The elimination period is 7 days for disability due to injury and 7 days for disability due to sickness.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>SUPPLEMENTAL STD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Amount</td>
<td>66.67% of weekly earnings</td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td>$2,000 per week</td>
</tr>
<tr>
<td>Benefit Duration</td>
<td>Up to 26 weeks</td>
</tr>
<tr>
<td>When Benefits Begin</td>
<td>After 7 days of sickness or injury</td>
</tr>
</tbody>
</table>

Long Term Disability

- Long Term Disability coverage provides important financial protection for your family in the event of an extended recovery from accident or illness.
- All eligible full-time employees can qualify to receive Long Term Disability coverage.
- The Long Term Disability benefit is calculated at 60% of your monthly base salary to a maximum of $10,000 monthly.
- The elimination period is 180 days.
- Benefits are provided, as long as continuously disabled, to the greater of age 65 or Social Security Normal Retirement Age. However, if disability occurs on or after age 63, benefits will be based on a schedule in compliance with ADEA.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>VOLUNTARY LTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Percentage</td>
<td>60% of pre-disability earnings</td>
</tr>
<tr>
<td>Definition of Disability</td>
<td>own occupation to age 65</td>
</tr>
<tr>
<td>Maximum Monthly Benefit</td>
<td>$10,000</td>
</tr>
<tr>
<td>Elimination Period</td>
<td>180 days</td>
</tr>
<tr>
<td>Maximum Benefit Duration</td>
<td>Social Security Retirement Age</td>
</tr>
<tr>
<td>Pre-existing Conditions Limitations*</td>
<td>3/12*</td>
</tr>
</tbody>
</table>

*A “Pre-Existing Condition” means the insured employee received medical treatment, consultation, care or services including diagnostic measures or took prescribed drugs or medicines in the 3 months just prior to his/her effective date of coverage; and the disability begins in the first 12 months after the employee’s effective date of coverage unless you have been treatment free for 12 consecutive months after your effective date of coverage.

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
### Employee Supplemental Life Insurance
- You may elect optional Supplemental Life Insurance in $10,000 increments, up to a maximum of 5 times your basic annual salary or $500,000, whichever is less. Full-time employees working at least 30 hours per week are eligible for Supplemental Life insurance.
- Evidence of Insurability must be submitted and approved for amounts in excess of $200,000.
- If you enroll in coverage lower than $200,000, you can increase up to the $200,000 amount without answer medical questions.
- The cost of this insurance is paid at 100% by the employee through post-tax payroll deductions.
- Benefits are reduced to 65% of original benefit at age 65, 50% at age 70.

### Voluntary Dependent Life Insurance
- You may elect Voluntary Dependent Life Insurance in $5,000 increments, up to a maximum of $500,000.
- Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself.
- Evidence of Insurability must be submitted and approved for amounts in excess of $25,000.
- If you enroll in coverage lower than $25,000, you can increase up to the $25,000 amount without answer medical questions.
- Benefits are reduced to 65% of original benefit at age 65, 50% at age 70.
- You can get up to $10,000 of coverage in $2,000 increments for children up to age 19 (or 26 if full-time student).

### Optional Accidental Death & Dismemberment (AD&D) Insurance
- Optional AD&D Insurance may be purchased in the same increments as life insurance.
- AD&D is not subject to Evidence of Insurability.

### Benefit Table

<table>
<thead>
<tr>
<th>Benefit Amount</th>
<th>Employee</th>
<th>Spouse</th>
<th>Dependent Children**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Amount</td>
<td>5 times (5x) annual salary in increments of $10,000</td>
<td>Increments of $5,000</td>
<td>Increments of $2,000</td>
</tr>
<tr>
<td>Minimum Benefit Amount</td>
<td>$10,000</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Maximum Benefit Amount</td>
<td>$500,000</td>
<td>100% of the Employee amount</td>
<td>$10,000 (Benefit for children from birth to 6 months $1,000)</td>
</tr>
<tr>
<td>Guaranteed Issue Amount*</td>
<td>$200,000</td>
<td>$25,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Reduction of Benefits Schedule</td>
<td>65% of original benefit at age 65 50% of original benefit at age 70</td>
<td>65% of original benefit at age 65 50% of original benefit at age 70</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Guaranteed Issue means the maximum amount of coverage available (to new hires) without medical information required. If you have previously purchased coverage, you can increase it up to $200,000 with no Evidence of Insurability. If you previously declined coverage, you will need to answer health questions.

**One policy covers all of your children until their 19th birthday or 26th birthday if they are full-time students.

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
Voluntary Accident Insurance
Accident insurance pays specific benefit amounts for injuries in a covered accident to help with the out-of-pocket costs that your existing coverage may not cover, such as:
- Emergency Room co-payments, coinsurance and deductibles.
- Medical treatment for fractures and dislocations or physical therapy.
- Crutches, wheelchairs or other medical aids you may need as a result of your accident.

Voluntary Critical Illness Insurance
- Fortunately, the odds of surviving a critical illness are in your favor, but would you be prepared for the many expenses that can accompany a critical illness? Even if you had health insurance, that coverage may not pay for everything, such as coinsurance, deductibles, caregivers, special medical equipment, household modifications and extra living expenses. Critical Illness Insurance complements your major medical coverage by providing a lump sum payment of either $5,000 or $10,000 to you. This program pays you for the following specified diseases:
  - Coronary artery disease, heart attack, stroke.
  - Benign brain tumor, end stage renal failure, major organ failure.
  - Cancer, carcinoma in situ (CIS).

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
Wagner College is offering pet benefits to employees at exclusive group rates! You can choose to enroll in one, two or three plans. Choose the plans that work best for you and your pets.

Pets Best Pet Health Insurance
Pets Best offers a pet health insurance plan that offers 90% reimbursement on accidents and illnesses. You can also choose to add on routine care coverage. Pets Best also includes a 24/7 Pet Help Line powered by whiskerDocs. To get your pet’s individual quote, visit petbenefits.com/land/wagneredu.

Pet Assure Veterinary Discount Plan
Pet Assure is a veterinary discount plan that can be used as an alternative or addition to pet insurance. Members save 25% at participating veterinarians on all in-house medical services, including office visits, vaccinations, x-rays and surgeries. It also includes a 24/7 Lost Pet Recovery Service at the low cost of $11.00/month for a family plan or $8.00/month for one pet. For a list of participating veterinarians, go to www.petbenefits.com/search.

PetPlus Prescription Discount Plan
With PetPlus, you receive members-only pricing on prescriptions and everything else your pet needs, including prescriptions, preventatives, food, treats and more. View available products and pricing at www.petplusbenefit.com. PetPlus also includes a 24/7 Pet Help Line powered by whiskerDocs. The cost for this plan is $3.75/month for one pet or $7.50/month for a family plan. Visit petbenefits.com/land/wagneredu to learn more about your plan options and how to enroll.

QUESTIONS? Call BenefitsVIP at 866.286.5354

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
Wagner College has partnered with Liberty Mutual to offer employees a special savings opportunity on customized auto and home insurance.

Along with valuable savings, enjoy access to benefits such as:

**Accident Forgiveness**
Your price won’t go up due to your first accident.

**Violation Free Discount**
Customers can earn a discount for 3 years of violation-free driving. Get an even larger discount when you reach 5 years.

**Preferred Contractor Network**
If your home incurs a covered loss, Liberty Mutual will connect you with reliable local contractors who can fix your problem quickly and at a competitive price. Liberty Mutual will even guarantee the contractor’s work for three years.

**Personal Property Replacement Cost Coverage**
In the even of a covered loss, Liberty Mutual will pay the actual cash value for items at the time of loss, then up to the full amount of the cost in today’s market.

**24-Hour Roadside Assistance**
If your car breaks down, Liberty Mutual stranded. From a jump-start to a tow, the optional 24-Hour Roadside Assistance will get you moving again.

**How do Liberty Mutual’s rates compare?**
As an employee of Wagner College you may qualify for special savings on your auto and home insurance. A Sales Representative will help ensure you get all the discounts you’re eligible for.

**What are my payment options?**
Liberty Mutual offers several convenient options. Plus, you get a special savings for paying your bill in full or choosing automatic payments, such as Electronic Funds Transfer. You can opt to:
- Have your payments deducted automatically from your checking/savings account.
- Pay monthly, quarterly or in one lump sum.

**Always there for you.**
When you have a claim, Liberty Mutual takes care of it. It’s that simple. You can call or go online 24/7. The mobile app makes things even easier:
- Pay your bill.
- Update your policy.
- Report, track, and manage your claims.
- Download from the App Store or using Google Play today!

For your free quote, call:
800.699.4378
Or Visit: www.libertymutual.com/wagnercollege
Client Number: 137004

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
Opt-in to Cyber Safety. No one intends to be unsafe online. Help protect your identity and devices with Norton LifeLock Benefit Plans. Let us help you empower you and your family to live your digital lives safely.

Take advantage of one of the protection plans being offered by Wagner College: Benefit Essential and Benefit Premier

Online Privacy
Norton Secure VPN protects devices and helps keep online activity and browsing history private. Privacy Monitor scans common public people-search websites to help you opt-out. And SafeCam alerts you and blocks attempts to access your webcam.

Identity
We monitor for fraudulent use of personal information, and send alerts when a potential threat is detected.

Home & Family
Take action to monitor your child’s online activity with easy-to-use tools to set screen time limits, block unsuitable sites, and monitor search terms and activity history.

Device Security
Anti-virus software and multi-layered, advanced security helps protect devices against existing and emerging threats, including malware and ransomware.

If you want to enroll, complete the LifeLock application and submit it to Human Resources

Questions about the program?
Call LifeLock Employee Benefits Member Support
800.607.9174

Questions about enrolling?
Call Human Resources
718.390.3116

For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
Access Your Employee Perks Program Today


We’re here to support your personal and financial well-being through exclusive deals and limited-time offers on the products, services and experiences you need and love. Start saving on:

- Electronics
- Appliances
- Apparel
- Cars
- Flowers
- Fitness Memberships
- Gift Cards
- Groceries
- Hotels
- Movie Tickets
- Rental Cars
- Special Events
- Theme Parks
- And more!

New to Plum Benefits? Getting Started is Easy

Maximize your time away from the workplace and start saving today

**Step 1:** Visit PlumBenefits.com.
**Step 2:** Click “Become a Member.”
**Step 3:** Enter your company code or work email to create an account.

Your company code
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For additional plan information, please refer to your detailed plan design provided by the carrier. In the event of a discrepancy, the carrier Plan Document shall prevail.
NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996 (NEWBORN’S ACT)
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET’S LAW)
Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and surgical reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an “alternate recipient’s” right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An “alternate recipient” is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)
If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)
If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE’S LAW
Michelle’s Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child’s leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan, whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008
This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

• The employee’s or dependent’s state Medicaid or CHIP (Children’s Health Insurance Program) coverage terminates because of coverage...

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)
GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee’s “genetic information,” which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.

GINA also prohibits employers from requesting, requiring, or purchasing an employee’s genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B]. This benefit, known as “continuation coverage,” applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

CHILDREN’S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)
Effective April 1, 2009 employers and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

• The employee’s or dependent’s state Medicaid or CHIP (Children’s Health Insurance Program) coverage terminates because the individual cease to be eligible.

• The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children’s Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

PREMIUM ASSISTANCE UNDER MEDICAID AND 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 may be eligible 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 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 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, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid Website: http://myahcoeff.org/ Phone: 855.692.5447
This benefit summary provides selected highlights of the employee benefits program available. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. 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. Our company 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.