Nemours Benefits

2022 Benefits Guide

NEMOURS
CHILDREN'S HEALTH

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Dear Associate and Family:

Your Benefits Guide is designed to provide you with an overview of the benefits offered through the Nemours Children's Health benefits plans.

Nemours Children's Health works hard to maintain quality, sustainable and inclusive benefits that meet the needs of our diverse associates population and their eligible dependents. Offering a competitive benefits package helps attract the best talent and retain our valued associates.

To that end, we are pleased to share this summary of our comprehensive benefits package. We even provide some benefits **at no cost to you** (if you are in a benefits-eligible role), such as:

- The Spousal Advantage Value Incentive (SAVI) Plan offered through Catilize Health that pays 100 percent of your out-of-pocket costs if you enroll in eligible alternative medical coverage
- Life and AD&D basic insurance coverage at one times your earnings, $500,000 maximum
- Short term disability (60 percent of your base salary for up to 13 weeks)
- Parent leave (100 percent of your base salary for up to 13 weeks)
- Tuition reimbursement of up to $5,250 annually
- Financial counseling services
- Advocacy support
- Adoption assistance
- Wellness program
- Retirement savings plan, plus matching contributions from Nemours Children's if you contribute

And, all associates and their family members have access to the Resources for Living Employee Assistance Program with eight free visits for each reason, including Talkspace chat and televideo options.

Benefits enrollment is one of the most important tasks for new or newly eligible associates. To get the benefits you want, you must enroll within 30 days of your date of hire. If you miss this opportunity, you will have to wait until you experience a qualified life event or the next annual enrollment. And for long term disability benefits, not signing up when first eligible means that you may have to provide additional documentation in order to get the coverage at a later date.

We encourage you to take advantage of the many benefits opportunities explained here. Please take the time to carefully review the material in this guide and at NemoursBenefitsGuide.com so that you can make an informed decision about your benefits. If you have questions, please call the Nemours Benefits Center at 855.373.6012 or email NemoursBenefits@bswift.com.

We welcome any suggestions or feedback you may have about our benefits programs.

Sincerely,
Nemours Children's Health Benefits Team

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Introduction to Your Benefits Program

Your Benefits Program is Nemours' comprehensive benefits plan for Nemours associates and their families. It gives associates the opportunity to choose benefits that meet their personal needs.

This guide provides summary information to assist associates in making their benefit choices. This is not a contract; the complete terms and conditions are described in the plan booklets that are available online. The information in this guide is a summary of benefits only. If there is a discrepancy between the information provided in this guide and the Summary Plan Description (SPD), the SPD will govern.

Enrollment

All new or newly eligible associates have 30 days from their date of hire to enroll or waive their benefits online.

Effective Date

Your benefits begin the first of the month following or coinciding with your hire or status change date. This is your waiting period. For example, if your first day of employment is Feb. 3, your benefits begin March 1. If your first day of employment is Feb. 1, your benefits begin Feb. 1. Your benefits remain in effect until Dec. 31 of each year and you may not make a change mid-year unless you have a Qualified Life Event.

Eligibility Definition

Associates:

All full-time benefits-eligible associates (working 30–40 hours a week or 0.75 – 1.00 FTE) and all part-time benefits-eligible associates (working 20–29 hours a week or 0.50 – 0.749 FTE) who have satisfied the waiting period, are eligible to participate in the Nemours Children's Health benefits program.

Spouse:

Your legal spouse.

Dependent Children:

Dependent children may be covered through the end of the month during which they turn 26 years of age, and beyond the age of 26 if disabled before age 26. A disabled child must be certified as disabled prior to the age of 26 AND must be primarily supported by the associate.

The following children are eligible to be covered under the Nemours Children's Health benefits plans, regardless of residence or financial dependency:

- an associate's biological or adopted child
- an associate's stepchild (defined as the child of your legal spouse)
- an associate's legal ward
- an associate's foster child (to age 18 only, letter of placement required)
- a child for whom an associate has a Qualified Medical Support Order (QMSCO)

According to the above requirements, the following dependents would NOT be eligible for coverage under Nemours Children's Health benefits plans:

- opposite-sex and same-sex domestic partner
- common law spouse
- divorced or legally separated spouse
- children who live in the associate's home and are financially dependent but who are not legal wards of the associate (for example, grandchild or child of opposite-sex or same-sex domestic partner)

Dependent Verification

Any dependents added to the Nemours Children's Health benefit plans—this includes spouses and children—are subject to an eligibility verification process. If you elect dependent coverage, you will be asked to provide documentation (e.g., birth or marriage certificate, tax return, etc.) to verify your dependents' eligibility. **Please note, your dependents will not be enrolled for benefits until you have provided the required documentation and their eligibility has been verified. Dependent verification must be completed within 60 days of associates completing their enrollment elections**.

Spousal Surcharge

If your spouse is eligible for health insurance through his/her employer but you elect to cover him/her on the Nemours Children's health plan, you will pay an additional $300 per month ($150 semi-monthly) in payroll contributions for this coverage. The surcharge is not applicable if your spouse does not have coverage available through his/her employer; your spouse does not work; your spouse works at Nemours Children's Health; or your spouse is self-employed.

Status Changes and Qualified Life Events

If you experience a change in status, or a Qualified Life Event (QLE), you may be able to make changes to your benefits elections mid-year. Examples of QLEs include marriage, divorce, birth of a child, adoption, loss of coverage and some other specific events. You will find a complete listing of allowed mid-year changes online.

Is there a time limit to make a mid-year QLE change?

Yes. You have 60 days from date of the event to make changes online.

How do I request a mid-year QLE change?

Log on to **www.nemoursbenefits.com** and go to "My Profile" or click on "My Benefits" to start a QLE change. Some events—like marriage, divorce, loss of coverage—may be initiated in advance of the event date. You will be required to upload supporting documentation for all events. Your change will be pended until the submitted documentation can be reviewed and approved.

Nemours Children's Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

NemoursBenefits.com Information

Single Sign-On

If you are signed on to the Nemours network at work or at home through Connect2, you can access NemoursBenefits.com without entering a username or password. The enrollment link can be found on the Benefits pages of NemoursNet or on HR Self Service.

How to Log On - Outside of the Nemours Children's Health Network

First Time Users

1. Go to **www.nemoursbenefits.com**.
2. Enter your Username and Password:
   - Your Username is your Nemours network username.
   - Your Password is the last four digits of your Social Security Number.
3. Click on the "Log In" button.
4. Next, you will be asked to change your password.

Returning Users

1. Go to **www.nemoursbenefits.com**.
2. Enter your Username and Password and then click on the "Log In" button.
3. If you have forgotten your password, click on the "Forgot Password" link.

First Time Enrollment Information

You have 30 days from your date of hire to enroll.

Once you're ready to enroll, have the following information available:

- dependent names, birthdates and Social Security numbers
- documents to substantiate dependent eligibility

You may log in and update your benefits elections as many times as you need to in order to complete your enrollment within your 30-day election period.

Site Summary

"Home" provides links to frequently used documents and enrollment alerts.

"My Benefits" tab provides an overview of the benefits for which you are currently enrolled and the cost per pay period. You can start a QLE here, too.

"My Profile" tab contains a summary of your demographic information; allows you to verify and update beneficiary information; add a log-in security question; start a QLE; upload documents for dependent verification and QLE processing; and print an Enrollment Confirmation form.

"News" gives you access to the most recent benefits announcements.

"Library" contains the most recent plan booklets and forms.

"Help" has educational videos on a number of insurance-related topics.

Mobile Benefits Portal

It seems like the whole world has gone mobile, and benefits are no exception. With the mobile Benefits Portal, you can enroll on-the-go. Visit the Nemours Children's benefits site on a wide range of browsers and devices including iPhones, iPads, Android phones and other mobile devices, via the web at **www.nemoursbenefits.bswift.com**.

Medical

Nemours Children's Health offers comprehensive medical coverage for associates and their covered dependents. This includes prescription drug coverage (see the separate prescription drug section).

The medical plan is administered by Aetna. There are four levels of medical benefits – Red, Blue, White and Green. Contributions are made on a pre-tax basis. Plan types are described below.

PLAN TYPE	RED	BLUE	WHITE	GREEN
	PPO	EPO	PPO	HDHP HSA

- **Preferred Provider Organization (PPO):** Offers you the freedom to seek care from any provider that you wish. If you seek care from an in-network (participating) provider, you will either pay a co-pay or deductible and coinsurance, and you will not be balance billed. Out-of-network charges will be paid at a lower level, and you will be responsible for any charges over Aetna's recognized charge. You may be balance billed for services performed by an out-of-network (non-participating) provider.

- **Exclusive Provider Organization (EPO):** An EPO shares essentially the same network as the PPO, but there are no out-of-network benefits associated with the EPO. In that respect, it is similar to an HMO. Emergency services and services that you are unable to choose (such as anesthesiology, ambulance and emergency room) will be paid at the in-network level.

- **High Deductible Health Plan (HDHP) with Health Savings Account (HSA):** Provides both in- and out-of-network benefits through the same PPO. Includes an HSA.

ID Cards

Digital medical ID cards are available within the Aetna app. Physical cards will be mailed to your home. All family members will have the same unique identifier. ID cards are not re-issued every year, so please keep your cards. If additional ID cards are necessary, please contact Aetna directly.

Participating Providers

The Nemours plans use the national Aetna network, so no matter where you live or work, there are in-network providers near you.

To locate participating providers, go to the "Find a Doctor" tool at www.Aetna.com. For the plan name, select Choice POS II (Red, White or Green Plans) or Aetna Select (Blue Plan).

Please see the Benefits Summary on the following pages for brief descriptions of benefits offered through each plan.

Benefits Summary – Red, Blue and White Plans

Plan Benefits	Red (PPO)		Blue (EPO)	White (PPO)	
	In-Network	Out-of-Network[1]	In-Network ONLY (EPO)	In-Network	Out-of-Network[1]
Deductible Coinsurance (what the plan pays) All-inclusive Out-of-Pocket Maximum (includes deductible, coinsurance, medical and Rx co-pays)	$500 Individual / $1,000 Family 80% $4,000 Individual/$8,000 Family	$1,000 Individual / $2,000 Family 60% $8,000 Individal/$16,000 Family	$600 Individual / $1,200 Family 80% $4,000 Individual/$8,000 Family	$1,200 Individual / $2,400 Family 70% $4,000 Individual/$8,000 Family	$2,400 Individual / $4,800 Family 50% $8,000 Individal/$16,000 Family
Primary Care Office Visits **Specialist Office Visits**	$30 co-pay $40 co-pay	60% 60%	$40 co-pay $50 co-pay	$40 co-pay $50 co-pay	50% 50%
Wellness/Routine Care Physical Exams/Vision Exam Well-Child Care Routine & Diagnostic Mammograms	100% 100% 100%	60% 60% 60%	100% 100% 100%	100% 100% 100%	50% 50% 50%
Diagnostic X-Ray & Lab Services Outpatient	X-Ray 80%, Lab 80%	60%	X-Ray 80%, Lab 80%	X-Ray 70%, Lab 70%	50%
Hospital Benefits Inpatient Outpatient	80% 80%	60% 60%	80% 80%	70% 70%	50% 50%
Surgical Benefits Inpatient Outpatient	80% 80%	60% 60%	80% 80%	70% 70%	50% 50%
Emergency Room (co-pay waived, if admitted) **Urgent Care Center** **Ambulance Services**	$250 co-pay $50 co-pay $50 co-pay	$250 co-pay $50 co-pay $50 co-pay	$250 co-pay $50 co-pay $50 co-pay	$250 co-pay $50 co-pay $50 co-pay	$250 co-pay $50 co-pay $50 co-pay
Mental Health/Substance Abuse Inpatient, Partial Hospital and Intensive Outpatient Care Office Visits	80% $40 co-pay	60% 60%	80% $50 co-pay	70% $50 co-pay	50% 50%
Chiropractic (30 days maximum per calendar year) Short-term Rehab: Physical, Speech, Occupational, Cardiac or Cognitive Therapy	$40 co-pay $40 co-pay	60% 60%	$50 co-pay $50 co-pay	$50 co-pay $50 co-pay	50% 50%
Prescription Drug Generic Rx Preferred Brand Rx Non-Preferred Brand Rx Maintenance Medications (90-day supply)	$10 co-pay 20% what you pay (min. $30, max. $60 40% what you pay (min. $60, max. $120) 2.5 x co-pay or coinsurance 2.0 x co-pay or coinsurance (Nemours Onsite Pharmacy)	Not Covered	$10 co-pay 20% what you pay (min. $30, max. $60) 40% what you pay (min. $60, max. $120) 2.5 x co-pay or coinsurance 2.0 x co-pay or coinsurance (Nemours Onsite Pharmacy)	$10 co-pay 20% what you pay (min. $30, max. $60) 40% what you pay (min. $60, max. $120) 2.5 x co-pay or coinsurance 2.0 x co-pay or coinsurance (Nemours Onsite Pharmacy)	Not Covered
Prescription Drug Specialty**	80% 20% what you pay (min. $100, max. $200)	Not Covered	80% 20% what you pay (min. $100, max. $200)	80% 20% what you pay (min. $100, max. $200)	Not Covered

[1] All out-of-network benefits are subject to balance billing. If there is a discrepancy between the information here and the plan document, the plan document governs. This chart does not describe all plan exclusions or limitations.
**Specialty medications included on the SaveOnSP drug list may be filled through the SaveOnSP program at significant cost savings to you. Please note that manufacturer assistance for the drugs on the SaveOnSP list requires program enrollment and will not be used to satisfy the deductible and out-of-pocket maximum.

Benefits Summary – Green Plan

The Green Plan is a high deductible health plan (HDHP) with a health savings account (HSA). You may enroll yourself, your spouse and your dependents in this plan.

The Green Plan is a PPO, with both in- and out-of-network medical benefits. It uses the same Aetna network of participating providers as the other Nemours Children's Aetna plans. Coverage includes office visits, diagnostic X-ray and laboratory, hospital, surgical, urgent and emergency care, mental health and many other services. In-network preventive care, including routine mammograms, is covered at 100 percent. Unlike the other Nemours Children's health plans, you pay 100 percent of non-preventive medical services until you meet the plan's annual deductible.

Prescription coverage is also included and is administered by Express Scripts. Most prescriptions are covered at 80 percent after your deductible; however, the plan also covers certain generic preventive medications (on the Standard Plus list) for a $10 co-pay. These are preventive medications not already covered at 100 percent and include medications for many chronic conditions including asthma and diabetes.

See below for a summary of the Green Plan benefits:

Plan Benefits	In-Network	Out-of-Network[1]
Employer HSA Funding	$250 Individual / $500 Family	
Aggregate Deductible*	$2,500 Individual / $5,000 Family	$5,000 Individual / $10,000 Family
Coinsurance	80%	50%
Out-of-Pocket Maximum (includes deductible)	$5,000 Individual / $10,000 Family	$10,000 Individual / $20,000 Family
Wellness / Routine Care Physical Exams / Vision Exam Well-Child Care Routine Mammograms	Covered at 100%	50% after deductible
Diagnostic Mammograms	100% after deductible	50% after deductible
Physician Office Visits	80% after deductible	50% after deductible
Diagnostic X-ray and Lab Services	80% after deductible	50% after deductible
Hospital	80% after deductible	50% after deductible
Surgical	80% after deductible	50% after deductible
Urgent Care	80% after deductible	50% after deductible
Emergency Room	80% after deductible	
Prescription Drug**	80% after the deductible $10 co-pay for non-ACA preventive generics 100% for ACA preventive generics	

*Note: if more than one person is covered, the family deductible must be met before benefits are paid.
** Co-pay assistance dollars for Specialty Rx will lower the Rx cost. Please note the manufacturer copay assistance will not be used to satisfy the deductible and out-of-pocket maximum.

Health Savings Account

The Green Plan also includes a Health Savings Account (HSA) to which you and Nemours Children's may contribute. The HSA is administered by PayFlex. The Nemours Children's Health contribution is up to $250 for an individual or $500 for a family. The Nemours Children's Health contribution is made semi-monthly. You may also make pre-tax contributions to the plan through payroll deductions or contribute tax-deductible amounts directly into your account. Your reimbursement cannot exceed your account balance.

The total contribution allowed in 2022, including both employer and associate contributions, is $3,650 (individual) or $7,300 (family). If you are age 55 or older, you may contribute an additional $1,000 to the account annually.

You are eligible to contribute to the HSA if:

- ✓ You are enrolled in a qualified High Deductible Health Plan

You are NOT eligible to contribute to the HSA if:

- ✓ You are covered by a spouse or have retiree coverage at another employer;
- ✓ You are claimed as a dependent on another person's tax return (except for your spouse);
- ✓ You are enrolled in an employer or spouse's General Purpose FSA; or
- ✓ You are enrolled in Medicare or Tricare

Unlike traditional FSAs which are 'use it or lose it,' unused funds contributed to the HSA may be rolled over from year to year and are available to you even if you are no longer employed by Nemours Children's Health. Associates who enroll in the Green Plan may also sign up for a Limited Purpose FSA which is only for dental and vision expenses.

Prescription Drug

Prescription drug benefits are administered by Express Scripts and are included in each of the Medical plans (see summaries on previous pages).

ID Cards

ID cards will be mailed to your home. Associates with single coverage will get one card; associates with dependent coverage—regardless of the number of covered dependents—will get two ID cards with the associate's name. Additional cards may be ordered by contacting Express Scripts.

How to Use the Program

Retail Prescriptions: Take your prescription(s) to any participating Express Scripts network pharmacy. Present your Express Scripts ID Card. You may purchase up to a 34-day supply of retail prescription drugs. If your doctor authorizes a refill, the same supply limitation will apply when your prescription is refilled. There may be prior authorization or step therapy required or quantity limitations on certain prescription drugs. Drugs purchased from non-participating pharmacies will not be covered. Contact Express Scripts for a list of participating pharmacies or search for a participating pharmacy online.

The cost of prescriptions will vary, depending on whether you receive a generic drug, a preferred-brand drug or a non-preferred brand name drug. We encourage you to review the Express Scripts formulary list available online. Express Scripts updates their formulary throughout the year.

Definitions

Generic

Generic drugs have been approved by the U.S. Food and Drug Administration (FDA) for quality and safety, and are absorbed in the same way as a brand name drug.

- Chemically Equivalent: have the same active ingredients, in the same quantities, as a brand name drug. The only differences are fillers and dyes.
- Therapeutically Equivalent: treat the same conditions as brand name drugs, but do not contain the same active ingredients.

Preferred Brand

Preferred brand name drugs are drugs still protected by patents (meaning no chemically equivalent generic is available). The FDA has approved these higher-cost drugs after trials show they are safe and effective. When a generic drug is introduced for a preferred brand name drug, the brand name will automatically move from Preferred Brand to Non-Preferred Brand. Check our carrier links regularly for updates.

Non-Preferred Brand

Associates will pay the most for non-preferred brand name drugs (which are listed in this tier for a variety of reasons). These drugs are non-preferred because there are other, lower-cost brand name drug(s) that are just as effective.

Generic Preferred Program

If you have a prescription for a brand name drug, and a *chemically equivalent* generic drug is available, you will have the option of choosing either the generic equivalent or the brand name drug. If you choose the brand name drug, you will pay the brand coinsurance or co-pay *plus* the difference in cost between the generic and the brand name drug.

Maintenance Medications - Smart90

Maintenance medications are ongoing, long-term prescriptions for conditions such as high blood pressure, high cholesterol and diabetes. Smart90 is a program managed by Express Scripts that gives you two ways to get a 90-day supply of your maintenance medications. You can conveniently fill these prescriptions either through home delivery (mail order) from the Express Scripts Pharmacy or from Walgreens, the Smart90 network pharmacy for our plan. Your physician must write the prescription for a 90-day supply.

You are allowed two fills of maintenance medications from other retail pharmacies before you must switch to Walgreens or home delivery. If you continue to use 30-day supplies or fill at a pharmacy that is not part of the Smart90 network, you will pay 100 percent of the cost of your maintenance medication. Please note that you may fill 90-day prescriptions for maintenance medications without penalty at Nemours outpatient pharmacies as noted below.

For more information regarding the Smart90 program, please contact Express Scripts directly, via their website or toll-free number listed at the end of this guide.

Cholesterol Care Value Program

Specialty drugs for high cholesterol – called PCSK9 inhibitors – are managed through Express Scripts Cholesterol Care Value Program. These drugs (for example, Praluent and Repatha) require prior authorization to be covered and, if approved, must be filled through Accredo, the Express Scripts specialty pharmacy (see below).

Accredo Program

Specialty medications (usually high cost or injectable drugs) must be filled through Accredo, a leading specialty pharmacy, and may require prior authorization. Through the Accredo program, you will have access to:

- a patient care coordinator who serves as your personal advocate and point of contact
- delivery of your specialty medications directly to you or your doctor
- supplies to administer your medications — at no additional cost
- care management programs to help you get the most from your medications

If you are taking a specialty medication, your first prescription fill may be at your normal retail pharmacy. You will then receive correspondence from Express Scripts on how to transfer your prescription to Accredo.

SaveOn SP Program

A specialty pharmacy copayment assistance program (also referred to as the "SaveOn SP program") is administered by Express Scripts. Please note that while participation in the SaveOn SP program is voluntary, and must be affirmatively elected by a participant — certain specialty prescription drugs will be considered non-essential health benefits under the Plan. If you participate in the SaveOn SP program, the cost of these specialty drugs to you will be $0. If you do not elect to participate in the SaveOn SP program, you will be responsible for the copayments of the specialty drugs, which may be significantly increased. Regardless of whether you participate in the SaveOn SP program, the cost of such specialty prescription drugs will not be applied toward satisfying your maximum out-of-pocket limit under the Plan's medical options. Additional information regarding the SaveOn SP program will be made available to you by Express Scripts.

Nemours Outpatient Pharmacies

Associates may also fill prescriptions for themselves and their families at the Nemours Children's Hospital, Delaware, at the Nemours Children's Hospital, Florida, or at Nemours Children's Specialty Care, Jacksonville. A 90-day supply of a maintenance medication can be filled at these Nemours outpatient pharmacies for only two times the applicable co-pay or coinsurance. While the 90-day supply will be the most cost-effective option in most cases there are some exceptions due to certain retail pharmacy pricing arrangements.

Spousal Advantage Incentive (SAVI) Plan

For those who are eligible, SAVI provides a unique opportunity to have no out-of-pocket medical costs other than the premium you pay for alternative coverage. If you have access to eligible alternate group medical and prescription drug coverage, SAVI **offers 100 percent coverage with $0 out-of-pocket for medical**. You will be reimbursed for **all eligible co-pays, coinsurance and deductibles** incurred through your alternative medical plan up to the maximum out-of-pocket limits under the Affordable Care Act ($8,700/single and $17,400/family per year). No premium contribution will be deducted from your Nemours Children's Health paycheck. You will not be charged the $300 monthly spousal surcharge by Nemours Children's if you enroll in SAVI.

Please note that the following alternative medical plans are NOT compatible with SAVI, so you are NOT eligible if your alternative medical plan is:

- Tricare
- Medicare
- Medicaid
- a high deductible plan with an active HSA contribution (this includes both employee and employer contributions)

If you have questions about SAVI, please contact Catilize Health at 877.872.4232 or email MERP@catilizehealth.com.

Voluntary Vision

Nemours offers a Voluntary Vision program through Vision Service Plan (VSP) on a pre-tax basis. There are two levels — the Base option and the Premium option. VSP is a PPO Plan, and offers you the freedom to seek care from any provider that you wish. If you use an in-network (participating) provider, you will generally pay a co-pay. If you utilize an out-of-network doctor, you may be reimbursed up to the amounts shown in the chart below. Children are covered with the associate.

Benefits	Base	Premium
Eye Exam	$10 co-pay	$10 co-pay
Single Vision, Lined Bi-focal, Lined Tri-focal and Lenticular Lenses	$25 co-pay	$25 co-pay
Progressive Lenses	$55 - $175 co-pay, depending on type of lenses	$55 - $175 co-pay, depending on type of lenses
Frame Allowance Featured Frame Allowance Discount on Balance Costco and Walmart/Sam's Club Allowance	$130 $150 20% $70	$180 $200 20% $100
Contact Lens Services (exam & fitting)	Up to $60 co-pay	Up to $60 co-pay
Contacts (instead of glasses)	$120 allowance	$150 allowance
Out -of-Network Benefits		
Exam ... up to $40	Lined Bifocal Lenses ... up to $50	Progressive Lenses ... up to $50
Frame ... up to $70	Lined Trifocal Lenses ... up to $65	Contacts ... up to $105
Single Vision Lenses ... up to $30		

To Utilize Your VSP Benefits:

1. Consult your VSP booklet for coverage details.
2. Find a VSP doctor online or by phone 24-hours-a-day.
3. Make an appointment with a VSP doctor and identify yourself as a VSP member.

There is no ID card, so be sure to identify that you are a VSP member. Your doctor will take care of the rest.

NOTE: Our Medical Plan also includes a vision discount program, and covers one eye exam every 12 months. Your Medical and VSP Vision discounts cannot be combined.

Dental

Nemours Children's Health provides Dental benefits through Delta Dental. There are three levels of dental coverage: Red, Blue and White. Contributions are taken on a pre-tax basis.

Passive PPO Network

A passive PPO allows you to choose any dentist. Although the reimbursement percentages are the same for in- or out-of-network coverage, you will save on out-of-pocket expenses by receiving services from an in-network dentist. The Nemours Children's Health plan uses both the Delta Premier and PPO networks. You can go online to find an in-network provider in your area; please use the contact information at the end of the guide. Definitions of "reasonable & customary" and "maximum allowable charge" are available in the Appendix section of this guide.

ID Cards

ID cards and a welcome letter that lists all covered dependents will be mailed to your home. Each enrolled associate will receive two ID cards. Dependent ID cards will not be provided.

Coverage Type	RED - Reasonable & Customary Plan	
	In-Network	Out-of-Network*
Preventive*** Basic Restorative Major Restorative Orthodontia - Child(ren) up to age 26 & Adults	100% 80% 50% 50%	100% 80% 50% 50%
Deductible** Individual Family	 $50 $150	 $50 $150
Annual Maximum Per Person	$2,000	$2,000
Orthodontia Lifetime Maximum Per Person	$2,000	$2,000

*All Out-of-Network benefits are subject to balance billing based on Reasonable & Customary Charges **Applies only to Basic and Major Restorative Services
***Space maintainers are covered at 80%

Coverage Type	BLUE - Reasonable & Customary Plan	
	In-Network	Out-of-Network*
Preventive*** Basic Restorative Major Restorative Orthodontia - Child(ren) Only up to age 26	100% 80% 50% 50%	100% 80% 50% 50%
Deductible** Individual Family	 $50 $150	 $50 $150
Annual Maximum Per Person	$1,500	$1,500
Orthodontia Lifetime Maximum Child(ren) Only	$1,500	$1,500

*All Out-of-Network benefits are subject to balance billing based on Reasonable & Customary Charges **Applies only to Basic and Major Restorative Services
***Space maintainers are covered at 80%

Coverage Type	WHITE - Maximum Allowable Charge Plan	
	In-Network	Out-of-Network*
Preventive*** Basic Restorative Major Restorative	100% 80% 50%	100% 80% 50%
Deductible** Individual Family	 $50 $150	 $50 $150
Annual Maximum Per Person	$750	$750

*All Out-of-Network benefits are subject to balance billing based on the amount that would have been paid to an in-network provider for the same service.
**Applies only to Basic and Major Restorative Services
***Space maintainers are covered at 80%

Frequency Schedule

The following procedures have limitations on the frequency with which the procedures can be performed, as follows:

Procedure	Frequency Schedule
Full Mouth X-Rays	Preventive - 1 per 60 months
Bitewing X-Rays	Preventive - 1 per calendar year for Adults/1 per 6 months for Children
Fluoride	Preventive - 1 per calendar year, to age 19
Sealants	Preventive - 1 sealant per permanent 1st and 2nd non-restored molar in 60 months, to age 19
Replacement of crowns, inlays and onlays*	Major Restorative - 1 in 5 years *Also includes partial and complete dentures; post and cores, veneers and stainless steel crowns, implants, bridges

Basic Term Life and Accidental Death & Dismemberment (AD&D)

Nemours Children's offers a Basic Term Life and Accidental Death & Dismemberment (AD&D) benefit of one times your base annual salary to a maximum of $500,000. Term Life insurance does not accrue a cash value and terminates when you leave employment. This benefit is employer-paid for all full-time and part-time benefits-eligible associates. Note that the IRS requires Nemours Children's to tax you on the value of this benefit that exceeds $50,000.

Voluntary Term Life

Associates may elect Voluntary Term Life insurance through Reliance Standard. Contributions are taken on a post-tax basis. Voluntary Term Life Insurance is portable but not permanent. Term Life insurance does not accrue a cash value.

Associates may purchase Voluntary Term Life insurance in increments of $10,000 up to the lesser of $1,000,000 or five times your base annual salary. Guaranteed Issue coverage is available for newly eligible associates up to $500,000. Amounts over the Guaranteed Issue for newly eligible associates are subject to Evidence of Insurability (E of I). All elections for late enrollees are subject to E of I. At Annual Enrollment, associates currently enrolled in the plan may increase their election by one level ($10,000) without E of I, up to the Guaranteed Issue amount of $500,000. Any additional amounts elected over the Guaranteed Issue level will be subject to E of I.

Associates may purchase Term Life insurance for their spouse in increments of $10,000 to a maximum of $380,000. Coverage amounts for spouses are limited to 100% of the associate coverage amount. Guaranteed Issue coverage is available for newly eligible spouses in the amount of $100,000. Any late enrollments, any increases over $10,000 (allowed at Annual Enrollment) or amounts over $100,000 will be subject to E of I. All elections are subject to E of I for late enrollees.

Associates may purchase Term Life insurance for their child(ren) in units of $2,500 to a maximum of $10,000. All amounts are Guaranteed Issue for newly eligible children. Premiums for child life are per unit, which means that the payroll deductions will remain the same regardless of the number of children covered by the plan. Dependent Children may be covered until the end of the month during which they turn age 26, but must be unmarried and financially dependent on the associate for support.

Voluntary Accidental Death & Dismemberment (AD&D)

Associates may elect Voluntary Term AD&D insurance through Reliance Standard. Contributions are on a post-tax basis.

Associates may purchase additional AD&D for themselves, in increments of $10,000, up to the lesser of $500,000, or 10 times earnings for elections over $150,000 (i.e., if you earn $10,000 a year, you may still elect $150,000).

Coverage may also be purchased on a family basis, which covers you, your spouse and/or your dependent children as follows:

- A spouse with no dependent children is insured for 100 percent of the associate's AD&D benefit. A spouse with dependent child(ren) is covered for 60 percent of the associate's AD&D benefit, while each dependent child is covered individually at 10 percent of the associate's AD&D benefit.
- If there is no spouse, each dependent child is insured for 15 percent of the associate's AD&D benefit.

Voluntary Long Term Care

Nemours Children's Health offers Long Term Care (LTC) coverage through the convenience of post-tax payroll deductions for both associates and their spouses. Direct billed coverage is also available to the parents and grandparents of associates and their spouses. Coverage for Long Term Care insurance is fully portable.

Long Term Care (LTC) coverage provides an allowance for custodial assistance to individuals who are unable to perform two of six Activities of Daily Living (ADL) due to a disability. ADL include bathing, dressing, eating, toileting (grooming), continence (using the bathroom without help), and transferring (moving from the bed to a chair, or vice versa). LTC is also payable if the subscriber has a cognitive impairment.

Custodial assistance may be provided by any of the following: a skilled nursing facility, a home health care agency (called Professional Home Care), an assisted living facility, or a member of the community (Total Home Care, including your family members).

Newly eligible associates may elect Long Term Care coverage without providing Evidence of Insurability (E of I) within 30 days of their eligibility effective date. All elections for late enrollees are subject to E of I determination; all elections made by eligible dependents are also subject to E of I.

Provision Options	3-Year Benefit Duration	6-Year Benefit Duration
Monthly Facility Benefit Amount Options	$1,000 to $4,000	$1,000 to $4,000
Skilled Nursing Facility*	100%	100%
Assisted Living Facility*	60%	60%
Total/Professional Home Care	50%	50%

*LTC pays a percent of the total Monthly Facility Benefit Amount, based on where services are received. For example, if a Facility Monthly Benefit Amount of $1,000 was elected, and services were received at a Skilled Nursing Facility, the benefit amount received would be 100% of $1,000; equaling $1,000 of benefit per month. However, if a Facility Benefit Monthly Benefit Amount of $1,000 was elected, and services were rendered at an Assisted Living Facility, the benefit amount received would be 60% of $1,000; equaling $600 of benefit per month.

**The Lifetime Maximum does not change based on where you receive services. If the Facility Benefit Amount elected is $1,000 for a 3-year Benefit Duration, the Lifetime Maximum is $36,000. For example, if the subscriber is confined to a Nursing Home, he/she would receive the benefit for a duration of three years; assuming the same election, but if services are received at Home, the benefit would be pro-rated accordingly, and $500 would be the benefit received for a maximum duration of six years.

Short Term Disability

Full and part-time associates are automatically covered by our short term disability plan that offers income protection for disabilities caused by illness, accident or injury that are not work-related. Coverage is 60% of the associate's base weekly pay with no maximum weekly benefit amount. The benefit period is a maximum of 13 weeks, inclusive of a 7-day elimination period. Premiums are paid 100% by Nemours. Evidence of Insurability is not required and there are no pre-existing condition limitations. Please note that if you work in a state that has a state-provided disability benefit (for example, New Jersey), our benefit payments will be reduced by any disability benefits received from the state.

Parental Leave

If you are in a benefits-eligible role (.50 full-time equivalency or greater) you are eligible for six weeks of paid (100 percent) parental leave. This is in addition to short-term disability benefits. Note that you must be eligible and employed by Nemours Children's Health prior to the birth of the child.

Voluntary Long Term Disability

Nemours Children's Health offers Long Term Disability insurance to associates through NY Life. Contributions are taken on a post-tax basis.

Long Term Disability insurance offers income protection for disabilities caused by illness, accident or injury. All benefits are subject to carrier approval. There are two plans offered to all. Note that Plan 3 is available only to associates earning more than $70,000 annually.

All Long Term Disability Plans include a pre-existing condition limitation. Newly elected plans or plan changes will be subject to a pre-existing condition limitation.

Provisions	LTD Plan 1	LTD Plan 2	LTD Plan 3
Eligibility	All Benefits-Eligible Associates	All Benefits-Eligible Associates	Associates earning more than $70,000 annually
Elimination Period	90 Days		
Benefit Duration	Up to Social Security Normal Retirement Age. If you become disabled after this age, there is a reduced benefit.		
Benefit Percent	50%	60%	60%
Monthly Maximum	$10,000	$12,000	$12,000
Own Occupation Duration	24 Months Own Occupation	24 Months Own Occupation	Own Occupation to Social Security Normal Retirement Age

Voluntary Accident

Nemours Children's Health offers MetLife Accident Insurance through convenient post-tax payroll deductions for associates, spouses and dependents. Accident Insurance provides you and your eligible family members with payment for a covered accident. It also pays if you undergo testing, receive medical services, treatment or care for any one of more than 150 covered events as defined in your group certificate. This includes hospitalization resulting from an accident and accidental death or dismemberment.

There are two options – high and low – that vary in the amount of payment for each covered accident. Payments are made directly to you to use as you see fit. They can be used to help pay for medical plan deductibles and co-pays, out-of-network treatments, your family's everyday living expenses, or whatever else you need while recuperating from an accident. Included in the MetLife Accident Insurance benefit is an annual $50 health screening benefit for each covered family member.

Your accident coverage is guaranteed, regardless of your health. You just need to be actively at work for your coverage to be effective. There are no medical exams to take and no health questions to answer.

Voluntary Critical Illness

Nemours Children's Health offers MetLife Critical Illness Insurance through convenient post-tax payroll deductions for associates, spouses and dependents. Critical Illness coverage provides you with a lump sum payment if you or your covered family members are diagnosed with a serious medical condition. The MetLife Critical Illness Insurance plan covers more than 20 illnesses or conditions including cancer, heart attack, stroke, coronary artery bypass, kidney failure, major organ transplant and Alzheimer's disease.

This insurance pays cash benefits directly to associates and their family members diagnosed with any of the covered conditions and in addition to any benefits paid through the health plan. It is designed to help offset the deductibles, co-pays and indirect costs associated with a serious illness.

You have a choice of three benefit levels – a payment of $10,000, $15,000 or $30,000 upon initial diagnosis — with a total benefit amount available of three times the initial benefit amount ($30,000, $45,000 or $90,000) in the event you suffer more than one covered condition. Your spouse is covered for 100 percent of the associate amount and children are covered for 50 percent of the associate amount. Included in the coverage is an annual $50 health screening benefit for each covered family member.

Coverage is guaranteed (no health questions asked) and there is no pre-existing condition limitation; however, you must be actively at work for your coverage to be effective. Premiums are based on the associate's age and tobacco use.

Voluntary Hospital Indemnity

Nemours Children's offers MetLife Hospital Indemnity Insurance through convenient post-tax payroll deductions for associates, spouses and dependents. Hospital Indemnity Insurance provides you and your eligible family members with payments when you are admitted or confined to a hospital due to an accident or illness. Typically, a flat amount is paid for admission and a daily amount is paid for each day of a hospital stay. It also pays extra benefits for admission to or confinement in an intensive care unit (ICU), and for other benefits and services.

There are two options – high and low. Payments are made directly to you to use as you see fit and independent of any benefits paid through the health plan. They can be used to help pay for medical plan deductibles and co-pays, for out-of-network stays, for your family's everyday living expenses, or for whatever else you need while recuperating from an illness or accident.

Your Hospital Indemnity coverage is guaranteed. You just need to be actively at work for your coverage to be effective. There are no medical exams to take and no health questions to answer.

Voluntary Identify Theft Protection

Nemours Children's offers Identity Theft Protection through InfoArmor, an industry leader in digital identity and financial wellness protection. InfoArmor's Privacy Armor is a monitoring solution that protects you from the hassles of identity theft. InfoArmor's Identity Theft Protection benefit includes the following services:

- Identity and tri-bureau credit monitoring
- Annual credit report and monthly credit score tracking
- Social media reputation monitoring
- Threshold monitoring
- Digital wallet storage and monitoring
- Full-service remediation
- $1 million identity theft insurance policy
- Deceased family member coverage
- Credit freeze assistance
- Tax fraud refund advance
- 403(b)/401(k) and HSA reimbursement

Coverage is available for you and your family, at an affordable rate. Identity Theft Protection will cover members of your household for whom you are financially responsible, "Under roof, under wallet."

Pre-Paid Legal Plan

Nemours Children's offers a popular Pre-Paid Legal plan through MetLife Legal Plan®. Contributions are taken post-tax. The MetLife Legal Plan is a simple, affordable way to access the most frequently needed personal legal services such as wills, powers of attorney and identity theft defense. Divorce is not covered. Some of the covered services include:

- family and personal law such as adoption, guardianship and garnishment defense
- money matters such as identity theft defense, debt collection defense and personal bankruptcy
- vehicle and driving law such as driving privileges restoration and license suspension
- home and real estate law such as foreclosure, eviction defense and title disputes
- civil lawsuits such as small claims assistance and disputes over consumer goods
- estate law such as simple wills, powers of attorney and health care proxies
- elder care law related to your parents

MetLife Legal Plan gives participants access to a network of more than 11,000 attorneys. Attorneys in the network meet stringent criteria and are regularly reviewed to ensure they continue to meet plan standards. Both in-network and out-of-network benefits are available.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) are available to associates through convenient payroll deductions on a pre-tax basis to help cover the cost of eligible expenses (as defined by the IRS). There are several FSAs available. These accounts have been established to cover different needs, as follows:

- **Health Care Spending Account:** Covers expenses not covered or partially covered by health, dental, prescription drug and vision programs such as co-pays and deductibles for you and your eligible dependents.
- **Limited Purpose Spending Account:** This is a special health care spending account available only if you enroll in the High Deductible Health Plan. It follows the same rules as the Health Care FSA but is only for dental and vision expenses.
- **Dependent Care Spending Account:** Covers expenses for day care or similar care to eligible dependents as defined by the IRS.
- **Mass Transit Spending Account:** Covers expenses for public transportation related to the commute to and from work.
- **Parking Spending Account:** Covers expenses for public parking related to the commute to and from work.

Associates may elect to participate in one or more of these accounts in any combination. Health Care, Limited Purpose and Dependent Care Spending Account elections are based on an ANNUAL election amount; you will need to calculate how much you want to set aside for the plan year of Jan. 1 - Dec. 31 in a lump sum. Mass Transit and Parking Spending Account elections are based on a MONTHLY election amount. This monthly election will remain in place throughout the plan year unless you change it.

Deductions will be taken equally from each paycheck on a pre-tax basis (24 pays for bi-weekly payroll; 12 pays for monthly payroll); only those associates who elect these accounts will be enrolled. After you've enrolled, as you incur eligible expenses (as defined by the IRS) throughout the plan year, you pay yourself back with the pre-tax money in your FSA account.

If you terminate employment, or if you become ineligible for the plan, please refer to the termination chart available online for information about how long you may incur additional claims and deadlines for submitting those claims for reimbursement. These time periods vary by account.

Tax Effect
Contributions to FSAs reduce the amount of taxable income. This results in savings of FICM, FICA, federal and state income taxes.

Health Care Flexible Spending Account

Health Care Flexible Spending Accounts (FSAs) help pay for expenses that are either partially covered or not covered by Medical/Prescription Drug, Dental or Vision insurance. You may contribute up to $2,750 in the account. You may participate in this account even if you have not enrolled in a Medical/Rx Plan.

Examples of Health Care Expenses Not Covered by Insurance: • Deductibles • Co-payments • Coinsurance

For extensive details on qualified expenses, log into the FSA/Commuter Portal by clicking the link for "FSA/Commuter Balance Inquiry" found on the Home Page of NemoursBenefits.com. Once you have been transferred to the FSA Portal, select the link for "Health Care Expenses Table" found at the bottom of the screen. In general, you may use a Health Care FSA to pay most health care expenses that qualify as a medical deduction for federal income tax purposes (as described in the IRS Publication 502) for yourself or your tax dependents. Health care expenses reimbursed through the FSA account cannot be claimed as deductions for federal income tax purposes.

Additional Claim Information

If you submit a claim for an amount higher than what you have contributed year-to-date to your FSA, you will be reimbursed up to the amount of your plan year election. Reimbursement consideration is based on when the service is rendered or a purchase is made, not when payment is submitted.

- You may use your debit card at an authorized vendor to avoid out-of-pocket costs for eligible expenses. (See FSA Debit Card section for more information on this option.) Alternatively, you may submit a paper claim via fax or email. We recommend scanning and e-mailing your claim form to your FSA vendor so that you have a record of the transmission.
- You may be required to provide an itemized receipt for your transaction. The IRS defines a valid receipt as a receipt that includes the vendor's name, a description of the purchase, the amount of the purchase and the purchase date.

Worksheet to Calculate Health Care Contributions

Use the worksheet below to list the out-of-pocket expenses you expect to incur during the plan year (beginning with the coverage effective date). This worksheet will assist you in estimating the total amount to deposit into the Health Care FSA.

Health Care Expenses Worksheet
(for you and your tax dependents)

	Estimated Costs:
Deductibles Note: if you usually do not meet the deductible, include only the amount you anticipate incurring.	$ _____
Co-payments	$ _____
Dental Co-pays or Costs not covered under the dental plan	$ _____
Vision exams, glasses or contact lenses, if not covered or only partially covered under insurance	$ _____
Medical Out-of-Pocket Costs not covered by insurance	$ _____
Other Allowable Medical Expenses	$ _____
Total	$ _____

- Amounts not claimed are forfeited under the "use it or lose it" federal requirement.
- Eligible charges must be incurred during the plan year or grace period. You will have 120 days after the end of the plan year to file eligible claims under the Health Care FSA (until April 30).

Dependent Care Flexible Spending Account

Dependent Care Flexible Spending Accounts allow you to set aside pre-tax dollars to provide care for your eligible dependents, so you (and your spouse) can work. This is for daycare expenses, not health care expenses for dependents.

Eligible dependents include anyone under age 13, your disabled spouse or other disabled person (including a parent or child), whom you can claim as a dependent for federal income tax purposes.

Costs for "activities" while a dependent is in a daycare are not eligible for reimbursement through the Dependent Care Flexible Spending Account. Examples of costs not eligible are: art, dance, piano and singing lessons. Only the cost for the actual daycare is eligible for reimbursement.

Examples of Eligible Dependent Care Expenses

- Child Daycare
- Adult Daycare

You may contribute up to $5,000 per plan year into a Dependent Care Flexible Spending Account. You may be reimbursed for the cost of care given inside or outside your home by a professional caregiver. Participants must provide the provider's EIN or Social Security Number for reimbursement. Please note that the provider must report the monies paid as income and pay taxes on that income.

To enroll in a Dependent Care Account you must meet at least one of the following qualifications:

- you are a single parent who works full-time
- you and your spouse both work, and your spouse's annual income is greater than the amount you are claiming for dependent care
- your spouse is enrolled full-time at a college or university for at least five months of the year
- your spouse is medically disabled and cannot care for himself/herself or your dependents

Note: If your spouse is a full-time student at least five months a year, or disabled, federal law limits the maximum pre-tax amount you may contribute. Contributions from highly compensated individuals may also be limited or amended as a result of federally required non-discrimination testing. Contact NemoursBenefits@bswift.com for details.

Worksheet to Calculate Dependent Care Contributions

Use the worksheet below to list the out-of-pocket expenses you expect to incur during the plan year (beginning with the coverage effective date). This worksheet will assist you in estimating the total amount to deposit into the Dependent Care Flexible Spending Account.

Dependent Care Expenses Worksheet	Estimated Costs:
Wages or Salary Paid to Caregiver	$ _____
FICA and Other Taxes you pay on behalf of caregiver, if applicable	$ _____
Payment to a licensed dependent care facility	$ _____
Eligible Expenses for care before and/or after your child goes to school	$ _____
Eligible Expenses for a housekeeper who provides care for a qualified dependent	$ _____
Total	$ _____

- Amounts not claimed are forfeited under the "use it or lose it" federal requirement.
- You may not be reimbursed for an amount in excess of the deposits you have made to date.
- Eligible charges must be incurred during the plan year (Jan. 1 - Dec. 31). You will have 120 days after the end of the plan year to file eligible claims under the Dependent Care FSA (until April 30).

Transportation Accounts

Transportation Flexible Spending Accounts allow you to set aside pre-tax dollars to cover mass transit or parking expenses related to your commute to and from work. There are two types of accounts: mass transit and parking. You may elect to participate in one or both of these accounts. The maximum monthly election is $270 for the mass transit account and $270 for the parking account.

Mass Transit Accounts

Mass transit eligible expenses include a transit pass, token, farecard, voucher or similar item entitling a person to transportation to and from work on a mass transit system. Some examples of mass transit include:

- trains
- subways
- trolleys
- buses

Expenses related to a Commuter Highway Vehicle may also be eligible, ONLY if all of the following requirements are met:

- must have seating capacity of six or more adults (not including the driver)
- at least 80 percent of the mileage use can reasonably be expected to be for purposes of transportation of employees between work and residences
- the number of employees carried is at least one-half of the adult seating capacity of such vehicle (not including the driver)

Accessing your mass transit account funds: Per IRS regulations, the debit card is the only method to access your available mass transit funds. Your debit card will be accepted only at merchants coded as a mass transit facility in the MasterCard transaction system such as a SEPTA or NJ Transit station. A convenience store that sells bus passes would NOT be recognized.

Parking Account

Eligible parking expenses include the cost of parking your car at a facility at or near your office location (e.g. parking garage or lot), or the cost of parking at a facility located at or near a location from which you commute to work (e.g. Metro parking lot, train station parking lot).

Accessing your parking account funds:

You may access your Parking account funds in two ways:

1. Use your debit card at a parking facility.
2. Paper Claims: Complete a request for reimbursement form and attach a statement of services. For parking boxes, a log of expenses including the date, amount of the charge and the facility name will be acceptable. Important: The IRS requires that you file for reimbursement within six months of the date the expense was incurred.

- Amounts not claimed at the end of the plan year will roll into the next plan year.
- You may change your election once per month, WITHOUT a Qualified Life Event.
- You may not be reimbursed for an amount in excess of the deposits you have made to date.

FSA Debit Card

All associates who participate in any Flexible Spending Account (FSA) benefits will receive one debit card — called a Prepaid Benefit card — to pay for qualified medical, dependent care, mass transit or parking expenses. The Prepaid Benefit card looks like a regular MasterCard but is only accepted at specific types of merchants or provider locations.

Once you've enrolled, be on the lookout for your card.
Debit cards will be mailed to your home in a plain unmarked white envelope. "Do Not Throw Away" will be written on the front of the envelope. Please read the cardholder agreement that is included with the card. Additional or replacement cards may be requested through the member site at no extra cost. Contact PayFlex Reimbursement Services at **855.516.8593**.

Activation is easy…
Your new Prepaid Benefit cards will arrive with a sticker on the front of the cards, and you must call the number listed to activate them. One phone call will activate both cards.

Where can I use the card?
You may use your debit card at the following locations:

- at any doctors' or dentists' office, or any hospital or clinic setting
- at a pharmacy, grocery store or discount store with an approved Inventory Information Approval System (IIAS system)
- at a daycare provider
- at a merchant coded as a mass transit or parking facility

If you use your card at an unqualified merchant, the transaction will be declined. You can download a list of merchants that have an IIAS system installed by entering the following web address in your browser: **http://apps.sig-is.org/SIGISPublicRpts/IIASMerchantList.aspx**.

What debit card transactions must be substantiated?
Certain debit card transactions will require you to submit physical documentation of the expense. Examples of such expenses include:

- any transaction that is processed at a merchant that does not have an IIAS system (including doctors' and dentists' offices) IF the amount is not a standard Nemours co-pay amount
- any transaction other than a Nemours co-pay amount that is not recurring

How do I substantiate a debit card transaction?
If documentation is needed, you will be notified of the item(s) that require substantiation. Sufficient substantiation must include: date the expense was incurred, the amount of the expense, a description of the service provided or item purchased, the name of the recipient (you, your spouse or dependent) and the name of the facility or provider. Examples of sufficient documentation include a detailed pharmacy receipt or an insurance Explanation of Benefits statement.

What happens if I do not submit documentation for my debit card transaction?
If documentation is not submitted, IRS regulations require that card access for that participant be temporarily suspended until you provide the applicable receipts or repay the plan. You will be responsible for reimbursing the plan — by check or through payroll deductions — for any unsubstantiated amounts. If recovery is not possible, you will be taxed on the value of the unsubstantiated expenses.

How long can you use your card?
Your Prepaid Benefit debit cards will be valid for five years. You will automatically receive new cards by mail during the month in which your card expires.

Other FSA Information

Please remember you can access your FSA through the Internet. You may view detailed information such as your account balance, claim status and payment information. This information will be available to you 24-hours-a-day, seven days a week. If you have any questions regarding your account, please call PayFlex FSA Customer Service at 855.516.8593.

To Access Your Account, Follow the Simple Steps Below

- Go to **www.nemoursbenefits.com**.
- Log on using your benefits Username and Password.
- Click on the "FSA/Commuter Balance Inquiry" link.

You will be automatically and securely transferred to the FSA/Commuter Portal. Here you can:

- check your FSA, Transit or Parking Plan balances
- input or update your Direct Deposit information
- check the approval and payment status of the claims you have submitted
- submit new claims for reimbursement (NOTE: substantiation for debit card claims should not be uploaded through the FSA/Commuter Portal)

Health Advocate

Health Advocate is a confidential, HIPAA-compliant service that is designed to help you make the most of your health care and health benefits. Health Advocate has a team of Personal Health Advocates — typically, registered nurses supported by medical directors and benefits and claims specialists — ready to serve as a resource to you and your family when you need one-on-one assistance with health care or insurance issues.

Health Advocate is provided to **all benefits-eligible** associates, at no cost to you and regardless of whether or not you are enrolled in the Nemours Children's benefits plan. This benefit covers your eligible family members, including your parents and parents-in-law. Health Advocate can help you and your eligible family members:

- find the right doctors within your plan's network
- schedule appointments with hard-to-reach specialists
- resolve insurance claims and untangle medical bills
- obtain prior authorizations and assist with appeals
- estimate the cost of health care services
- understand tests, treatments and medications
- locate elder care and support services
- facilitate the transfer of medical records
- find the newest medical treatments available

Resources for Living (Employee Assistance Program)

Resources for Living, Nemours Children's Employee Assistance Program (EAP), is more than just a counseling service. It is a holistic resource for helping associates balance work and life not only emotionally, but financially and legally as well. There is even a chat and a televideo option called Talkspace for members ages 13 and older that can enhance your coverage options. Resources for Living provides up to eight free sessions for each covered person for each issue annually. And, if you use the Talkspace option for chat or televideo, each week of either chat or televideo counts as only one session.

Resources for Living is a free, confidential, 24-hour/day, 365 days/year service sponsored by Nemours Children's. This benefit covers all members of your household, including dependent children up to the age of 26. Contact Resources for Living:

- by phone at **855.506.2373**
- **online at resourcesforliving.com**
  Username: Nemours
  Password: resources4living.

When logged on, you can access Talkspace to access a licensed therapist. You can also view the online library of tools. There is even an app that can be downloaded to access content on-the-go with a mobile device.

Wellness Program

Our Wellness Program is an investment in associates' health, both now and for the future. Nemours Children's Health has designed the program with one goal in mind: to improve your health. The program's focus is on increasing associate awareness and encouraging positive behavior changes through ongoing wellness education and activities. Participation in the program is voluntary; however, associates who successfully complete their annual wellness activities pay discounted rates for their medical coverage. Spouses enrolled in the Nemours Children's health plan are also eligible to participate.

The wellness program includes:

- access to an online wellness portal and health assessment
- educational programs focused on physical activity, weight management, stress reduction and smoking cessation
- access to wellness coaches
- fun, team and individual wellness challenges

Financial Finesse

Nemours Children's Health provides a financial education/planning benefit through Financial Finesse. This is a Nemours Children's-paid benefit, provided at no cost to all benefits-eligible associates. You will be automatically enrolled in this program. Financial Finesse offers unbiased and expert financial education, delivered by on-staff certified financial planners. This program is designed to help you understand and take charge of your financial "health" and to put in place strategies that can help you achieve your financial goals. The program includes online education and tools as well as live workshops and webcasts designed to reduce your overall stress, increase your financial knowledge and, with that knowledge, help you make informed financial decisions.

As part of this program, associates have 24/7 access to Financial Finesse's Online Financial Learning Center located at **http://www.ffhub.com/nemours** as well as unlimited access to phone-based financial guidance from a Certified Financial Planner™ through The Financial Helpline. The Helpline is open Monday through Friday, from 9 a.m. to 8 p.m. ET, and can be reached by calling **877.234.1782**.

Tuition Reimbursement

All benefits-eligible associates are eligible to participate in the tuition reimbursement program after successful completion of the 90-day evaluation period. Associates are eligible for up to $5,250 in tuition reimbursement benefits annually, pro-rated for part-time associates. Courses must be approved in advance and completed successfully (minimum grade of "C" or "pass"). Please note that repayment is required if you terminate or have a change in employment status within one year of reimbursement.

The program is administered by EdAssist and includes free educational advising and network discounts to help maximize your tuition reimbursement benefits.

Adoption Assistance

Nemours Children's provides Adoption Assistance benefits to full- and part-time benefits-eligible associates after the successful completion of the 90-day evaluation period. Nemours Children's will reimburse full-time associates for eligible adoption expenses up to the IRS maximum, with a pro-rated amount for part-time associates. Assistance is limited to three adoptions per family.

Most expenses directly related to the adoption are reimbursable. Eligible expenses include application fees, home studies, placement fees and travel expenses.

Retirement Plans

The Nemours Children's Health Retirement Plans are managed by Transamerica Retirement Solutions (TRS). There is a 403(b) Plan and a 457(b) Plan for Nemours Children's Health associates and a 401(k) Plan for associates of Children's Health Alliance, LLC.

New Nemours Children's associates are automatically enrolled in the 403(b) plan at a four percent (4%) of salary contribution level. Tax-deferred contributions will begin approximately 30 days after your hire date. Associates may change or stop their contributions at any time or may opt out by contacting Transamerica Retirement Solutions. Automatic enrollment does not apply to associates in the Children's Health Alliance 401(k) Plan.

403(b) Plan (for Nemours Chlidren's Health associates)

Matching and Base Contributions

If you are eligible, the plan provides a 50% matching contribution on your contributions up to 4% of eligible pay (maximum match of 2%), as well as a service-based basic contribution (3% to 8% of pay) made quarterly upon completion of at least 250 hours per quarter. If you are not eligible for employer contributions, you may make voluntary contributions to the 403(b) plan. A Roth savings feature is also available.

Employer Matching Contribution – If you have an FTE of .4807 or above, the match is made every pay period and is 50% of your contribution, up to 4% of eligible pay (maximum match is 2%). While your contributions are immediately vested, the Nemours employer-matching contributions will vest after three years.

Employer Basic Contribution – a service-based employer contribution is made quarterly if you are an FTE of .4807 or above and have worked at least 250 hours in the quarter. Basic, non-elective employer contributions are vested after three years.

Basic Contribution Years of Service	Contribution
0-4 Years	3%
5-9 Years	4%
10-14 Years	5%
15-19 Years	6%
20-24 Years	7%
25+ Years	8%

403(b) Contribution Example

You are eligible with three years of Nemours Children's Health service and if you have at least 250 hours of service each calendar quarter. Your compensation is $50,000 and you contribute 4% of your compensation to the Nemours Children's 403(b) Plan. The example below shows how your annual Plan contribution would be calculated:

4% x $50,000 = $2,000
(Your Contribution)

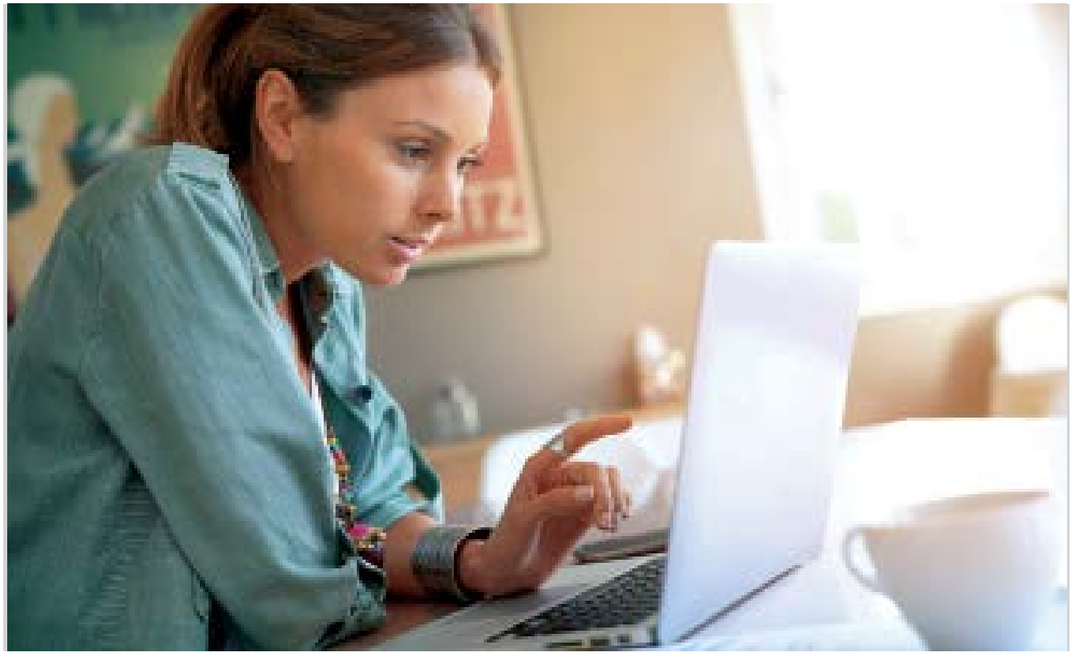
50% x $2,000 = $1,000
(Nemours Matching Contribution)

3% x $50,000 = $1,500
(Nemours Basic Contribution)

Total of Your and Nemours' Contributions = $4,500

457(b) Retirement Savings Plan

The 457(b) Retirement Savings Plan is a supplemental tax-deferred savings plan available if your annual base salary is $150,000 or more. This plan offers another way to save for retirement, in addition to saving through the 403(b) plan. Contributions are permitted up to the IRS limits which are indexed and may change from year to year. The 2022 limit is $20,500.



401(k) Retirement Savings Plan (for CHA associates)

All CHA associates are eligible to participate in the Pediatric Medical Services of Florida, Inc. 401(k) Plan as their retirement program. This is a tax-deferred savings plan that provides employer contributions to associates regardless of status. Contributions begin as soon as administratively possible following your election and are invested in a default investment fund if you fail to choose an investment allocation. Associates may change their contribution amount or investment selection at any time. Associates may contribute up to the IRS limits. For 2022, the limit is $20,500; associates age 50 or older may contribute up to an additional $6,500 for a total of $27,000. CHA provides a 50% matching contribution on associate contributions up to 4% of eligible pay (maximum match of 2%), as well as a basic contribution of 3% made annually based on your calendar year pay In addition to the 3% basic contribution, all CHA associates also receive an annual service-based basic contribution (0% to 5% of pay) according to the schedule below. All employer contributions are immediately vested.

Years of Service	Service-Based Contribution
0-4 Years	0%
5-9 Years	1%
10-14 Years	2%
15-19 Years	3%
20-24 Years	4%
25+ Years	5%

For more detailed information about these plans, including eligibility, employer contributions, investment options and plan limits, contact **Transamerica Retirement Solutions** at **888.676.5512** or online at **my.trsretire.com**.

Paid Time Off (PTO)

Full-time and part-time associates working at least 20 hours per week accrue PTO each pay period, according to position and length of service. For example, full-time associates (40 scheduled hours per week) with less than five completed years of service accrue 25 PTO days. You may carry time over from year to year, however, once the maximum or cap is reached, additional accruals stop until time is used. New associates are eligible to use PTO after 90 days.

Years of Service	Accrual Rate	Annual Accrual*	Maximum
0 through 5	0.0962 per hour paid/worked	25 days (200 hours)	31 days (248 hours)
6 through 15	0.1116 per hour paid/worked	29 days (232 hours)	36 days (288 hours)
More than 15	0.1231 per hour paid/worked	32 days (256 hours)	40 days (320 hours)

*Annual accrual shown is based on a 1.0 FTE.
Note: PTO accrual schedule and usage eligibility may differ for selected associates.

Paid Holidays

Full-time and part-time associates receive six holidays per year. There is no waiting period for eligibility. Holidays include: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day.

Volunteer Time Off (VTO)

Full-time associates who have completed the 90-day evaluation period receive eight hours of paid Volunteer Time Off (VTO) each year to use for community service activities (four hours for part-time associates).

Please note, paid time off plans may vary for physicians and residents.

Notes

Appendix

Glossary

All Inclusive Out-of-Pocket Maximum
The maximum amount an associate and their covered dependents will pay in a calendar year. Includes deductibles, coinsurance, and medical and prescription co-pays.

Allowable Charge
The carrier determines if the cost is reasonable for care and/or supplies. Providers that do not participate with the carrier (out-of-network) may ask for full payment of services. Claims may need to be submitted for payment; the carrier will pay the allowable charge to you, less any co-payment or coinsurance. This is the same payment that the carrier pays to the participating (in-network) providers. The member is responsible for any balance remaining, after the carrier payment.

Annual Enrollment
A period of time when people may enroll in health insurance and other benefits plans.

Balance Billing
Amount owed to an out-of-network provider after co-payment/coinsurance, after the carrier's payment has been made.

Coinsurance
The percentage of health care costs an individual must pay, once a deductible is met. For example, many plans pay 80 percent or 70 percent of the cost of care, and the patient is responsible for the remaining 20 percent or 30 percent. Some plans limit the amount of coinsurance a covered person must pay. See "Out-of-Pocket Maximum."

Coordination of Benefits (Birthday Rule)
If both spouses are working and carry dependent coverage, the responsibility for primary coverage falls to the parent having the earlier birthday in the calendar year, regardless of which parent is older. Coordination of Benefits does not apply to Prescription Drug.

Co-payment
A specified flat fee an individual pays for health care services or prescriptions. For example, the patient may pay a $30 co-payment for each doctor visit, or $10 for each prescription.

Deductible
The amount an individual must pay for services before a health care plan begins to pay benefits. Most plans have a maximum family deductible that is satisfied by the combined expenses of all covered family members, generally two to three times the individual amount. An "aggregate" deductible means that if more than one individual is covered, the family deductible must be met before expenses are paid.

Dependent
Additional members of an associate's household that are eligible to be covered by the group's policy. Generally these are children of the associate.

Effective Date
The date on which an insurance policy or benefit plan goes into effect and coverage begins.

Eligibility
Conditions to be met in order to receive a benefit or participate in a group benefit plan. Eligibility varies by plan. For associates, it is generally based on employment status (i.e., non-benefits-eligible to benefits-eligible). Eligibility for dependents is based on the benefit, age and relationship to the associate.

Elimination Period
The amount of time before the benefit payment will begin. Elimination periods typically refer to disability.

Emergency
An Emergency is defined as:

- a condition serious enough to cause a prudent person to seek emergency care
- a situation where a delay in care might cause permanent damage to your health
- a situation where you have care within 48 hours from the onset of the condition

Note: if you use the emergency room and it is not considered an emergency, the claim will not be covered, and you will be responsible for all charges.

Evidence of Insurability (E of I)
A statement or proof of a person's physical condition, occupation or other factors affecting his or her acceptance for insurance. May be required for disability, life or accident insurance over certain levels or for late enrollment.

Explanation of Benefits (EOB)
A statement from a health plan or insurance company sent to a group member who files a claim giving specific details about how and why benefits payments were or were not made. It summarizes the charges submitted and processed, the amount allowed, the amount paid and the subscriber balance, if any.

Guarantee Issue Amount (GI)
The amount of life or accident insurance an insurance company is willing to issue without evidence of insurability (proof of good health).

Health Insurance Portability & Accountability Act (HIPAA)
Federal legislation that improves access to health insurance when changing jobs by restricting certain pre-existing condition limitations. HIPAA also guarantees availability and renewability of health insurance coverage for all employers regardless of claims experience or business size.

Inventory Information Approval System (IIAS)
An electronic inventory system that identifies items that are eligible for purchase through an FSA or HSA.

Inpatient
A person who occupies a hospital bed, crib or bassinet while under observation, care, diagnosis or treatment for at least 24 hours.

Life Status Change (Qualified Status Change / Family Status Change)
The only time, other than Annual Enrollment, when an associate may change medical, dental, vision, flexible spending or other benefits coverage. Qualifying events include (but are not limited to) marriage or divorce, birth or adoption of a child, death of a spouse or dependent, gain or loss of employee or spouse's employment, or a change in job status that affects benefits coverage. Changes in coverage must be made within 60 days of the date of the qualifying event. (See page 5 for additional information.)

Lifetime Maximum
The total amount a dental insurance policy will pay over the course of an individual's lifetime.

Maximum Allowable Charge (MAC)
MAC is a method of reimbursement for charges. MAC is the discounted amount that is paid to an in-network provider for services rendered. A MAC plan pays an out-of-network provider at the same level as an in-network provider. All amounts above the MAC are the responsibility of the associate.

Medically Necessary
Services that are required to prevent harm to the patient or an adverse effect on the patient's quality of life, as judged against generally accepted standards of medical practice. The term is most often used to determine whether or not a procedure or service is covered by insurance.

Newly Eligible
Refers to individuals that are benefits-eligible for the first time due either to a new hire or status change.

Medicare
Administered by the Social Security Administration, Medicare is the U.S. federal government plan for paying certain hospital and medical expenses for those who qualify, primarily those individuals over age 65. Benefits are provided regardless of income level. The program is government-subsidized and government-operated.

Network
A selected group of physicians, hospitals and other health care providers who participate in a managed care plan and agree to follow the plan's procedures. Benefits for network care are generally optimized when using services provided by a participating professional.

Plan Year
The calendar or fiscal year on which the records of a benefit plan are kept. Health care plans, deductibles and benefits maximums are reset at the beginning of each plan year.

Portability
The ability to retain benefits coverage when changing jobs. For life insurance, this means changing the life insurance coverage to an individual term life policy that continues as long as the insured person pays the premiums.

Pre-Existing Condition
An injury or illness for which you have been diagnosed, received treatment or incurred expenses prior to the plan effective date. This term applies to disability benefits.

Pre-Tax Contribution
Contributions that are deducted from an associate's paycheck before federal, most state and local, and Social Security taxes are figured, reducing taxable income.

Primary Coverage
The health coverage most responsible for paying your claims if you have duplicate coverage.

Provider
Carrier-approved professionals or facilities that provide health care services, including physicians, hospitals, nurse practitioners, chiropractors, physical therapists and others.

Providers, In-Network
Health care professionals and facilities that participate in a specific plan's network. These also are known as participating or in-network providers. After payment of coinsurance or co-payments, the carrier will pay the remaining balance.

Providers, Out-of-Network
Health care professionals and facilities that do not participate in a specific plan's network. These also are known as non-participating or out-of-network providers. Expenses incurred from these providers may not be covered or may be only partially covered. After payment of coinsurance or co-payments, the carrier will pay the balance equivalent to the amount paid to an in-network provider; any outstanding monies owed after the carrier's payment will be the member's responsibility.

Spouse
Legally married spouses of associates are eligible to participate in the Nemours Children's Health Benefits Program.

Summary Plan Description (SPD)
A government requirement for a written description of a benefit plan in an easy-to-read form, including a statement of eligibility, coverage, associate rights and appeal procedure. It is provided to participants, beneficiaries and the Department of Labor upon request.

Underwriting
The process of identifying and classifying the potential degree of risk represented by an associate who enrolls for coverage. Plans that require underwriting may ask associates to provide medical or personal information at the time of enrollment.

Waiting Period
The length of time you must be employed before you become eligible for benefits, (i.e., the first of the month following or coinciding with the date of hire).

Waive
To intentionally decline coverage in a benefits plan; some plans require proof of coverage elsewhere.

Frequently Asked Questions (FAQs)

Medical

Where can I find a list of available doctors/hospitals?
Go to "Find a Doctor" at www.Aetna.com. Select Choice POS II (Red, White and Green Plan) or Aetna Select (Blue Plan).

What fertility benefits are being offered in the medical plans and are they available in all four plans?
Nemours Children's Health provides comprehensive and inclusive fertility benefits and additional pregnancy and parenting support resources. The benefit design allows you and your doctor to pursue the most effective treatment and provides coverage for two smart cycles. These fertility benefits are available in all four plans. You need to be enrolled in one of the four medical plans (Red, White, Blue or Green) to have the fertility benefits.

What if my spouse's employer offers benefits?
If you are currently enrolled in a Nemours Children's plan but have the opportunity to enroll in your spouse's plan (non-Nemours Children's), you will want to consider our SAVI plan. Your premium for SAVI is $0, and it will pay 100 percent of the out-of-pocket costs incurred from your spouses' medical plan up to the Affordable Care Act (ACA) maximums (2022 limits are $8,700/single and $17,400/family per year).

Note that SAVI is available if you are a new associate and enroll in alternative coverage (except for TriCare, Medicare, Medicaid and HSA plans) or if you are a current associate enrolled in a Nemours benefit plan and enroll in alternative coverage with the exceptions previously noted. You and your spouse should weigh which plan works best for your circumstances.

What is the spousal surcharge for 2022?
The spousal surcharge for 2022 is $300 per month. This surcharge is applicable only when your spouse has access to medical coverage through their employer and you decide to cover them through a Nemours Children's Health medical plan. If your spouse is not covered by Nemours Children's Health, there is not a spousal surcharge. Note that the spousal surcharge will continue to be waived if you both work at Nemours Children's Health. If your spouse has access to medical coverage from their employer, you can avoid the spousal surcharge and lower your out of pocket costs by enrolling in the SAVI Plan. Note that you are required to update the status of your spouse's coverage availability during enrollment.

Which of the plans has the greatest tax advantage?
The Green Plan includes a health savings account (HSA). An HSA account offers a triple tax advantage to those who enroll in it. Associates can contribute tax free, earn tax-free interest on their investments and use the funds for eligible medical expenses tax free.

Prescription Drug

How do I participate in the mail order drug plan with Express Scripts?
Refer to information available in the online benefits Library for specific instructions on how to enroll in the mail order plan.

How can I find out if the brand name drug that I am taking has a chemical equivalent?
A listing of chemically equivalent drugs is difficult to maintain because as brand name drugs lose their patents, new chemically equivalent generic drugs are manufactured. However, you may visit www.express-scripts.com, and enter the name of your brand name drug in the "Search" field on the left hand side of the page. If a number of options appear, click the name of the drug that matches the prescription you are taking. Information about that prescription drug will then appear. In the bank of information available at the top of the page, look for "Generic Available"—if this field indicates "yes," it means a chemically equivalent generic is available. If this field indicates "no," it means no chemically equivalent generic drug is currently available.

Please check back often, as brand name drugs regularly lose their patents and begin to be produced by other manufacturers.

How can I avoid paying the difference in cost between a brand name drug and a chemically equivalent generic drug?
You may ask your doctor to circle "Substitution Allowed" on the prescription that he writes for you. By law, your pharmacist may only substitute a chemically equivalent generic if your doctor has circled "Substitution Allowed" rather than "Dispense as Written."

There are certain exclusions to this rule as mandated by state law. (See the Express Scripts booklet for more detail.)

The brand name drug I am taking has a chemically equivalent generic drug available. I've tried the generic, and I had a bad reaction to the drug. What can I do?
Your physician may file an appeal with Express Scripts. They may provide you with a prior authorization that will allow you to fill your prescription without having to pay the difference in cost.

I use mail order for my prescription drugs. Will the Generics Preferred Program apply to my mail order medications?
Yes, this program will apply to mail order.

How will I be notified by Express Scripts if the cost of my mail order medication will be increasing?
If Express Scripts does not have a credit card on file for you, they will notify you if your order exceeds $150. If Express Scripts has a credit card on file for you, they will notify you if your order exceeds $500.

What happens if my doctor's request for a prior authorization is denied?
Our pharmacy benefit plan's guidelines exclude certain drugs from coverage. To learn more about what drugs are excluded under our plan, look in your plan summary.

For a copy of the criteria our plan uses to decide which prior authorizations will be covered, call Express Scripts. An agent can send you a copy of the criteria. The number to call is on the back of your prescription card.

OR

If you want to file an appeal to have your prescription drug covered, our plan has an appeals process. Call Express Scripts at the number on the back of your prescription card to get the address to which you should send your appeal.

Voluntary Vision

Do I need an ID Card?
No, you do not need to present an ID card to prove coverage or confirm that you are eligible. Identify yourself as a VSP member to your eye care provider.

What will be covered through this benefit?
This vision benefit provides added discounts when services are sought through the preferred provider listing. See page 14 for a summary of vision care benefits.

What providers are considered in-network?
For the most part, VSP only contracts with private ophthalmologists or optometrists. Most major eye care chains, such as Lenscrafters, Pearle Vision and Sears Vision are NOT covered as in-network providers by VSP because they do not meet VSP's quality assurance standards.

However, many of these chains will provide discounts for their eyewear if you identify yourself as a VSP member.

My eye care provider is out-of-network. How do I get reimbursed for my expenses?
An out-of-network claim form is available at www.nemoursbenefits.com in the online benefits Library.

Are my contact lenses "elective" or "necessary"?
If your contact lenses are considered medically necessary (in other words, you can't wear glasses), they will be reimbursed at 100 percent. If you have the option of wearing glasses or contacts, your contact lenses are considered "elective," and your allowance will be determined by the plan you elect.

I need both glasses and contact lenses — what should I do?
Frames may only be reimbursed one year after filling a prescription for contact lenses. We therefore recommend that you fill your prescription for glasses and lenses FIRST, and then, in the following calendar year, fill a prescription for contact lenses.

Contact lenses/lenses are considered interchangeable, so you may EITHER receive your allowance for lenses or for contacts in any given calendar year.

Are disposable contact lenses covered under this plan?
Yes. You may use your elective contact lens allowance toward disposable contact lenses. If your disposable lens charges are under the allowable amount for the calendar year, you may continue to be reimbursed for disposable lenses until you have reached the $120 or $150 allowance. Thereafter, you may be eligible for discounts on your disposable lenses.

Are polycarbonate or bicarbonate lenses covered for adults?
Charges for polycarbonate or bicarbonate lenses are not covered under the normal lens co-pay. However, you may elect to pay the extra charge for poly- or bicarbonate lenses.

I understand that if I wear soft contact lenses, I may be eligible for additional discounts — how does this program work?
Ask your doctor if you might be eligible to participate.

Under the soft contact lens program, instead of having an allowance toward contacts AND the contact fitting exam, you will receive a 15 percent discount off the contact fitting exam, PLUS a $120 or $150 allowance toward contact lenses. This program will generally allow you to receive six months of soft contact lenses without cost.

Dental

What is a participating dentist and how do I locate one?
A general dentist or specialist who meets strict credentialing standards and accepts scheduled fees as payment-in-full for services rendered. To get a list of participating dentists, call (800) 932-0783 to have a list faxed or mailed to you or go to the online provider search.

How does the Passive PPO Work?
With the Plan, you receive a wide range of benefits whether or not you and/or each eligible dependent visit a participating dentist. But, when you visit a participating dentist (an "in-network dentist"), you have the opportunity to make the most of your benefit plan through access to lower out-of-pocket expenses.

Can I find out how much services will cost and what will be covered prior to treatment?
Delta Dental strongly recommends that you have a dentist submit a pre-treatment estimate for services in excess of $300. While you wait, your dentist can get a real-time pre-treatment estimate online or over the phone in minutes detailing what services the plan will cover and at what payment level. PPO plans pay for the least expensive clinically appropriate course of treatment. Therefore, licensed dental consultants review certain services such as crowns, bridges and periodontics for appropriateness and necessity.

Do I need an ID Card?
No, you do not need to present an ID card to prove coverage or confirm that you are eligible. However, Delta Dental does issue ID cards to help identify you as a member of the Nemours Delta Dental program, and claims filing information is provided in the online benefits Library.

Term Life Insurance and Accidental Death & Dismemberment

Describe your Evidence of Insurability requirements. When would evidence be required (e.g., with change in election, when a salary increase causes an increase in benefit, after initial approval)? How often is evidence required?
Evidence is needed for anyone applying for amounts above the Guaranteed Issue limit, anyone applying after the eligible enrollment period or anyone wanting to increase coverage. This applies to both employee and spouse coverage. We also require Evidence of Insurability when the person does not elect coverage initially.

Disability

What is the most common cause of disability claims delays?
The most common reason that a Long Term Disability claim is delayed is that the claim form is not complete. To most effectively ensure the processing of a claim, check to be sure that all questions on the form are answered, the policy number is on the form and that the employer portion is completed by the Nemours Benefits Team.

Flexible Spending Accounts

What records do I keep for tax purposes?
Keep receipts for at least a year; the IRS requires auditing of certain debit card transactions. See the FSA Debit Card section for more information.

Can I use the Health Care FSA to pay for my spouse's deductibles and/or co-payments if they are not covered by my group medical plan?
Yes. However, health care premiums deducted from your spouse's paycheck and premiums for individual insurance policies are not eligible.

To what age may I use the Dependent Care FSA for daycare expenses incurred for my child?
You may submit expenses incurred for your dependent child before his/her thirteenth birthday, or longer if disabled.

Are expenses for before/after school programs considered eligible expenses?
Yes, but you must separate the cost of such care from the cost of the school.

Are Over the Counter (OTC) Medications Covered?
OTC medications are covered only if you have a prescription from your doctor. You may not use your debit card to purchase an OTC medication, but you may submit a claim for reimbursement. You must submit a copy of the script with the claim form in order for the expense to be reimbursed.

IMPORTANT NOTE FOR DIRECT DEPOSIT: Each individual bank has its own rules as to when it processes the direct deposit payments it receives. Associates should consult with their bank for details.

Termination of Employment

What happens to my benefits if I terminate employment with Nemours?
Your benefits options vary depending on what you had in force prior to your termination. Different benefits have different continuation options. For example, Medical, Dental, Vision and Health Care Flexible Spending Accounts may be continued for specified periods of time through COBRA. Term Life insurance may be ported or converted, and Long Term Care may be taken with you at exactly the same rates that you currently pay.

There are limits to the amount of time that you have to make elections to continue terminated coverage. You may find a detailed listing of benefits available upon termination (and information about those benefits) online, in the Termination of Benefits Summary.

How will my dependent child(ren)'s coverage be impacted by a status change or termination of employment?
Nemours provides coverage for your eligible dependent child(ren) until the end of the month during which they turn 26. You should be aware of how their benefits are impacted by certain circumstances such as turning 26. If you terminate employment with Nemours, your dependent children are eligible for COBRA. The COBRA options available to your dependents may vary depending on your status as an active employee (whether you are full-time or part-time), and your dependent's age as of termination.

Key Contact Information

Medical Plans (Group #285681)
Aetna
P: 855.878.4195
W: www.aetna.com or www.aetnanavigator.com

HSA Administration
PayFlex
P: 888.678.8242 W: www.aetna.com

Health Advocacy
Health Advocate
P: 866.695.8622 W: www.healthadvocate.com

Prescription Drug Plans (Group Nemours)
Express Scripts
P: 844.394.2932 W: www.express-scripts.com

Voluntary Vision Plan (Group # 30-010344)
VSP Vision
P: 800.877.7195
W: www.vsp.com E: imember@vsp.com

Dental Plans (Group # DE16770)
Delta Dental
P: 800.932.0783 W: www.deltadentalins.com

Basic & Voluntary Life Plans (Policy #139430)
and Voluntary AD&D (Policy #203320)
Reliance Standard
P: 800.351.7500 W: www.rsli.com

Accident, Critical Illness & Hospital Indemnity
MetLife
P: 800.438.6388
W: www.metlife.com/mybenefits

Voluntary Long Term Care (Group #546735)
UNUM
P: 800.227.4165
W: http://w3.unum.com/enroll/nemours

Short Term Disability
ReedGroup
P: 866.693.0064
W: www.nemours.org/reedgroup

Long Term Disability
(Policy number #UDT962675)
New York Life - LTD
P: 800.362.4462 W: www.cigna.com

Pre-paid Legal Program (Group # 6090282)
MetLife Legal Plan
P: 800.821.6400 W: www.legalplans.com
(password for "Thinking About Enrolling" is "GetLaw")

Identity Theft Protection
InfoArmor
P: 800.789.2720 W: www.infoarmor.com

Flexible Spending Accounts
PayFlex
P: 844.PAYFLEX (844.729.3539)
Available 24/7
F: 888.238-3539
W: www.nemoursbenefits.com, then
FSA/Commuter Balance Inquiry link

Employee Assistance Program (EAP)
Resources for Living
P: 855.506.2373
W: www.resourcesforliving.com

Tuition Reimbursement
EdAssist
P: 844.239.8771
W: www.tamsonline.org/nemours

Financial Education
Financial Finesse
Online Learning Center and Helpline
P: 877.234.1782
W: http://flc.im/nemours
(Access Code is Nemours)

Nemours Retirement Plans
Transamerica Retirement Solutions
(Acct. # TT069349, TI097889, QK62698)
P: 888.676.5512 or 800.755.5801
W: my.trsretire.com

Wellness
Allura Health | P: 800.362.4462
W: https://wellness-connect.net/index.php

Nemours bswift Benefits Center
P: 855.373.6012 F: 855.796.0800
W: www.nemoursbenefits.com
E: nemoursbenefits@bswift.com

NEMOURS
CHILDREN'S HEALTH

NemoursBenefitsGuide.com

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