

The University of Alabama Benefits Guide for Faculty and Staff





Welcome

Welcome to The University of Alabama – an institution rich in tradition! This guide provides pertinent information about the benefits offered to new employees. You may obtain additional information from the HR web site at <http://hr.ua.edu/benefits/index.html>.

New Employee Enrollment

New employees must enroll in benefits within 30 days of their date of hire. It is important that you review this material so you can enroll in benefits for which you are eligible and that meet your needs. The choices you make will be in effect for the remainder of the calendar year unless you experience a qualifying life event or family status change.

Directions

- To determine which benefits you are eligible to receive, turn to page 2 (Staff Benefits Eligibility Matrix), locate your employment status in the Employment Status Category Key at the bottom of the page.
- If you are eligible for:
 - Medical, Dental and Vision coverage and wish to enroll, complete the Benefit Enrollment/Change Form (*all forms are located in the Forms section*). If you decline coverage, indicate your declination on the form.
 - Flexible Spending Accounts and wish to enroll, complete the Flexible Spending Account Election Form. If you decline coverage, indicate your declination on the form.
 - University Paid Group Term and AD&D, complete the Group Term Life Insurance Beneficiary Form.
 - Teachers' Retirement System (TRS) 401(a) Plan, you must complete TRS Form 100.
 - The University of Alabama System 403(b) Plan and wish to enroll, go to www.myretirementmanager.com, click *I'm a New User* and then follow the instructions.
- Return all forms within 30 days of your date of hire to the HR Service Center.

Qualifying Life or Family Status Change

If you experience a qualifying life event during the year, you are permitted to revise your coverage to accommodate your new situation. There are two types of qualifying events.

- Family Status Changes: marriage, sponsored adult dependent 12 month residency or residency termination, divorce, childbirth, adoption of a child, death of a spouse/sponsored adult dependent/dependent, or a dependent child or sponsored child dependent reaching the age limit
- Employment Status Changes: the full-time equivalency (FTE) of your appointment with the university changes; your appointment type changes; or your spouse's or sponsored adult dependent's employment changes and affects benefit coverage

Be sure to notify the HR Service Center **within 30 days of a qualifying life event** to make any benefit changes.

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For Your Notes

Forms

- Benefit Enrollment & Change Form
- Flexible Spending Account (FSA) Election Form
- Flexible Spending Account (FSA) Request for Reimbursement Form
- MetLife Designation & Contingent Beneficiary(ies) Form
- TRS Form 100 Enrollment Form
- PrimeMail® Mail-Order Prescription Drug Order Form
- Application for Educational Benefit
- Application for Critical Illness

Notices

- COBRA Continuation of Coverage Notice

This guide is a summary and does not take the place of plan documents. If there is a conflict between this guide and the plan documents, the plan documents will govern.



Benefits “At a Glance” Matrix

10-11-11

Benefit	Who Pays	When Eligible**	What to Know
Medical Plan	UA & Employee	Immediately	Administered by Blue Cross/Blue Shield
Dental Plan	Employee	Within one month of hire date	Blue Cross Blue Shield Dental Plan
Vision Plan	Employee	Within one month of hire date	UnitedHealthcare Vision Plan
Flexible Spending Accounts	Employee	Immediately	Tax savings on medical and dependent care
University Paid LTD Insurance	UA	Immediately	Payments after 90 days of disability
University Paid Group Term Life Insurance	UA	Immediately	Coverage varies with salary
University Paid AD&D Insurance	UA	Immediately	\$22,500 coverage
Voluntary Group Term Life Insurance	Employee	Immediately	Additional group term life insurance
Voluntary AD&D Insurance	Employee	Immediately	Additional AD&D insurance
Teachers' Retirement System 401(a) Plan	UA & Employee	Immediately	* Mandatory 7.25% employee contribution
University of Alabama System 403(b) Plan	UA &/or Employee	Immediately	Tax exempt savings plan
University of Alabama System 457(b) Plan	Employee	Immediately	Deferral of income & taxes to later date
Educational Benefit Program	UA	Immediately for employee & 6 months for dependent	Employee & dependent tuition benefits
WellBama	UA	Immediately	UA Office of Health Promotion & Wellness
Employee Assistance Program	UA	Immediately	Confidential counseling & referral services
Voluntary Critical Illness Insurance	Employee	Immediately	Lump-sum payment for covered critical illness
Voluntary Long-Term Care Insurance	Employee	Immediately	LTC insurance at group rates
Annual Leave (vacation)	UA	Immediately	Generous paid vacation
Sick Leave	UA	Immediately	Equates to 1 day earned per mo. (PT leave prorated)
Holiday & Administrative Leave	UA	Immediately	Generous leave benefits

* TRS is not mandatory for Temporary Full-Time & Temporary Part-Time Faculty in year 1 but are eligible if FTE > .50. TRS is mandatory beginning 13th month.

** Most benefits require active enrollment by employee – some require enrollment within 30 days of start date or eligibility date.



Benefits Eligibility Matrix

Benefits	#	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	
Medical Plan		●	●		●	●	●	●	●		●	●	●	●	●	●		●	●	●	
Dental Plan		●	●		●	●	●	●	●		●	●	●	●	●	●		●	●	●	
Vision Plan		●	●		●	●	●	●	●		●	●	●	●	●	●		●	●	●	
Flexible Spending Accounts		●	●		●	●	●	●	●		●	●	●	●	●	●		●	●	●	
University Paid LTD Insurance		●			●		●	●				●	●	●	●				●	●	
University Paid Group Term Life Insurance		●			●		●	●				●	●	●	●				●	●	
University Paid AD&D Insurance		●			●		●	●				●	●	●	●				●	●	
Voluntary Group Term Life Insurance		●			●	●	●	●			●	●	●	●	●			●	●	●	
Voluntary AD&D Insurance		●	●		●	●	●	●	●		●	●	●	●	●	●		●	●	●	
Teachers' Retirement System - 401(a) Plan		●	●				●	●	● ¹	● ¹	● ¹	●	●	●	●	●	● ¹	● ¹	● ¹	●	●
University of Alabama System - 403(b) Plan		●	●	●	●	●	●	●	● ²	● ²	● ²	●	●	●	●	●	● ²	● ²	● ²	●	●
University of Alabama System - 457(b) Plan		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Educational Benefit Program		●	●		●		●	●	●		●	●	●	●	●	●		●	●	●	
WellBama		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Employee Assistance Program		●	●		●	●	●	●	●		●	●	●	●	●	●		●	●	●	
Voluntary Critical Illness Insurance		●	●		●	●	●	●	●		●	●	●	●	●	●		●	●	●	
Voluntary Long-Term Care Insurance		●	●		●	●	●	●	●		●	●	●	●	●	●		●	●	●	
Annual & Sick Leave		●	●											●	●	●		●	●		
Holiday & Administrative Leave		●	●		●		●	●	●		●	●	●	●	●	●		●	●	●	

#	Faculty and Staff Definition
1	Staff regular full-time & administrative faculty
2	Staff regular part-time
3	Staff temporary full-time, temporary part-time, contingent on call
4	Resident physicians
5	Post doctoral fellows
6	Faculty regular full-time 9/12 – tenure/tenure track only (includes Asst/Assoc Deans, Dept Heads, admin. appointments)
7	Faculty renewable full-time 9/12 – non tenure/non tenure track (multi-year, contract, clinical & renewable appointments)
8	Faculty regular part-time & renewable part-time 9/12 – tenure/tenure track & not TT (includes all tenure status types & clinical, multi-year, contract & renewable appointments)
9	Faculty temporary part-time 9/9 – non tenure/non tenure track (temporary academic appointments, 1 or 2 semester appointments only, not renewable)
10	Faculty temporary full-time 9/9 – non tenure/non tenure track (temporary appointments, 1 academic semester/yr only, not hired as renewable, e.g., full-time visiting faculty & full-time temp academic appt.)
11	Faculty renewable full-time 9/9 – non tenure/non tenure track (multi-year, contract, clinical & renewable appointees who choose to be paid 9 over 9 rather than 9 over 12)
12	Faculty regular full-time 9/9 – tenure/tenure track only (includes Asst/Assoc Deans, Dept Heads, & administrative appointments, for faculty who choose to be paid 9 over 9 rather than 9 over 12.)
13	Faculty regular full-time 12/12 – tenure/tenure track only (includes Dept Heads & other administrative appointments)
14	Faculty renewable full-time 12/12 – non tenure/non tenure track (multi-year, contract, clinical & renewable appointments)
15	Faculty regular part-time & renewable part-time 12/12 – tenure/tenure track & not TT (includes all tenure status types & clinical, multi-year, contract & renewable appointments)
16	Faculty temporary part-time 12/12 – non tenure/non tenure track (appointments are 1 yr or less & are not renewable)
17	Faculty temporary full-time 12/12 – non tenure/non tenure track (appointments are 1 year or less & are not renewable)
18	Deans, Asst/Assoc Deans, Asst/Assoc Provost 12/12 – tenure/tenure track & clinical (includes clinical executive appointments)
19	Deans, Asst/Assoc Deans, Asst/Assoc Provost 9/12 – tenure/tenure track & clinical (includes clinical executive appointments)

- (1) Participation is mandatory for appointments of one academic year or longer. Employees who currently participate in TRS under another employer will be required to contribute regardless of length of appointment or FTE.
- (2) Employee may participate in the plan, but is not eligible for the match.

Benefit Programs Summary

This quick reference guide provides a summary of the core benefits available to eligible employees. Questions about benefits, payroll or employment should be directed to the HR Service Center:

HR Service Center Phone: 205-348-7732
G-69 Rose Admin. Bldg. Fax: 205-348-8755

Health Plans

Medical Plan

Vendor: Blue Cross Blue Shield of Alabama
Website: www.bcbsal.com
Phone: 800-292-8868

The University offers excellent medical and prescription drug coverage which is administered by Blue Cross Blue Shield of Alabama. New employees have the option of making medical coverage effective the actual date of hire or the first of the month following the date of hire.

Dental Plan

Vendor: Blue Cross Blue Shield of Alabama
Website: www.bcbsal.com
Phone: 800-292-8868

A comprehensive dental plan is offered through Blue Cross. The plan allows participants the freedom to seek care from any dentist, but participants could incur significantly higher out-of-pocket expenses when out-of-network dentists are used.

Vision Plan

Vendor: UnitedHealthcare Vision
Website: www.myuhcvision.com
Phone: 800-638-3120

The vision plan is offered by UnitedHealthcare Vision, which has a provider network consisting of more than 30,000 private practice and retail chains nationwide. Eligible employees can receive a comprehensive eye exam and a pair of lenses once every 12 months and frames once every 24 months.

Flexible Spending Accounts

Vendor: Flexible Corporate Plans (FLEXCORP)
Website: www.flexcorp.com
Phone: 888-505-4557

Eligible employees can take advantage of flexible spending accounts which are administered by FLEXCORP. Participants can set aside pretax money via payroll deductions to pay for healthcare and dependent care expenses not covered by benefit plans. Money set aside in these accounts will reduce taxable income, providing participants with more value for the dollar.

Disability & Life Insurance Plans

University-Paid Long Term Disability Insurance

Vendor: The Standard
Website: www.standard.com
Phone: 800-368-1135

The University provides at no cost to eligible employees long term disability insurance through The Standard. The policy provides for salary continuation at 66 2/3% of current salary, not to exceed \$10,000 per month and begins on the 91st day of "total disability."

After 90 days of benefit payments, the plan changes from 66 2/3% to 60% of current salary and continues at that rate for the duration of the claim.

University-Paid Group Term Life Insurance

Vendor: MetLife
Website: www.metlife.com/mybenefits
Phone: 800-438-6388

The University provides at no cost to eligible employees a group term life insurance plan from MetLife. Coverage varies as follows:

Annual Base Salary	Coverage Amounts
Less than \$17,999	\$25,200
\$18,000 to \$23,999	\$30,000
\$24,000 to \$29,999	\$37,500
\$30,000 to \$39,999	\$50,000
> \$40,000	125% salary (\$300,000 max. benefit)

University-Paid Accidental Death & Dismemberment Plan

Vendor: MetLife
Website: www.metlife.com/mybenefits
Phone: 800-438-6388

The University provides at no cost to eligible employees an Accidental Death & Dismemberment (AD&D) policy from MetLife in the amount of \$22,500 payable if death was caused by an accident. For example, the employee's beneficiary would receive both the University-Paid Group Term Life and AD&D benefit if he/she dies in an accident. AD&D also pays a benefit if a serious injury results in dismemberment. For example, part of the benefit may be paid if the employee loses a limb or the ability to see. AD&D coverage also includes Travel Assistance Services. This service offers participants and dependents with medical, travel, legal and financial assistance services when faced with an emergency while traveling more than 100 miles away from home.

Voluntary Group Term Life Insurance

Vendor: MetLife
Website: www.metlife.com/mybenefits
Phone: 866-492-6983

Eligible employees have the option of purchasing additional term life insurance of up to five times the eligible employee's salary rounded up to the nearest \$10,000 with a maximum of \$1.4 million. The policy is guaranteed to be issued for employees electing the lesser of three times their salary or \$500,000 if the application is approved during the first 60 days of employment.

Voluntary Accidental Death & Dismemberment Insurance

Vendor: MetLife
Website: www.metlife.com/mybenefits
Phone: 866-492-6983

This benefit provides eligible employees additional Accidental Death & Dismemberment (AD&D) coverage with a minimum coverage of \$25,000. The amount selected may not exceed ten times the base annual earnings. New employees must enroll in the plan during their first 60 days of employment.

Retirement Plans

Teachers' Retirement System 401(a)

Organization: Teachers' Retirement System (TRS)

Website: www.rsa-al.gov

Phone: 877-517-0020

All eligible employees are required by state law to contribute 7.25% of their gross annual salary to TRS. This defined benefit program provides retired employees with a specific benefit payable monthly for the lifetime of the member. In addition to the employee contribution, the University contributes a percentage which is determined by the Alabama Legislature.

TRS members are eligible for retirement benefits at age 60 with 10 years of participating service, or at any age with 25 years of participating service. Accumulated sick leave at retirement may be converted to additional service credit. Upon service retirement, employees are also eligible to join the state's Public Education Employee Health Insurance Plan (PEEHIP). Rates for this plan vary based on years of TRS service.

Individuals resigning from employment before vesting in the program, or before qualifying to receive benefits, may request a refund of their contributions and applicable interest.

University of Alabama System 403(b) Plan

Vendor: TIAA-CREF

Website: www.tiaa-cref.org

Phone: 800-842-2776

Vendor: VALIC

Website: www.valic.com

Phone: 800-892-5558 ext. 88289

TIAA-CREF and VALIC are the two vendor through which eligible employees can participate in the University of Alabama System 403(b) plan. The plan allows participants to invest in mutual funds. Contributions are normally made on a pre-tax basis, but Roth post-tax contributions are now available.

The University makes a matching contribution for all regular full-time faculty and exempt staff contributions up to 5% of gross monthly pay to the 403(b) plan administered by TIAA-CREF or VALIC. Any contributions above 5% are not matched by the University.

University of Alabama System 457(b) Plans

Organization: Retirement System of Alabama (RSA-1)

Website: www.rsa.state.al.us

Phone: 800-214-2158

Vendor: TIAA-CREF

Website: www.tiaa-cref.org

Phone: 800-842-2776

Vendor: VALIC

Website: www.valic.com

Phone: 800-892-5558 ext. 88289

457(b) plans allows eligible employees to defer receipt of a portion of their salary until some later date, usually at retirement or termination of employment. Contributions are normally made

on a pre-tax basis, but Roth post-tax contributions are now available.

Contributions to 457(b) plans may be made instead of, or in addition to, any 403(b) contributions. Eligible employees may participate in both 403(b) and 457(b) plans in the same year, contributing up to the maximum amount allowed by federal law to each plan.

Miscellaneous Plans

Educational Benefit Program

Employees may be eligible for tuition assistance as of their hire date. Spouses and dependent children may be eligible for tuition assistance after the employee has completed 6 months of continuous eligible employment.

WellBama

Organization: The University of Alabama - Office of Health Promotion and Wellness

Website: wellness.ua.edu

Phone: 205-348-0077

WellBama is the University's signature wellness program for faculty and staff. Designed to promote health and improve the quality of life for all employees, this free, personalized program includes confidential health screening, health coaching, and a preventive examination, along with a wide range of resources and programs to motivate and support individual health goals.

Employee Assistance Program (EAP)

Vendor: DCH Health System

Website: www.dchsystem.com/eap

Phone: 205-759-7890 or call 866-840-0750

EAP offers free, confidential counseling and referral services for issues such as marital, family and emotional problems; substance abuse; financial and job-related concerns.

Voluntary Critical Illness Insurance

Vendor: Aflac

Website: www.aflac.com/ua

Phone: 800-433-3036

Critical Illness insurance plan is offered through Aflac. This coverage will pay eligible individuals a lump-sum payment if they are diagnosed with a covered critical illness such as cancer, heart attack, stroke, renal (kidney) failure. New employees have 30 days in which to elect coverage in amounts ranging from \$5,000 up to \$50,000 and \$25,000 for a spouse. Coverage will be effective the date the eligible employee signs the application.

Voluntary Long Term Care Insurance

Vendor: MetLife

Website: www.metlife.com/mybenefits

Phone: 866-492-6983

Long term care coverage is offered through MetLife. This coverage provides benefits for an array of services, including home health care, assisted living facility care, adult day care, and respite care.

Medical Plan Matrix

(Effective 1-1-2011)



BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
GENERAL PROVISIONS		
Deductibles (Medical and Prescription Drug)	A \$125 per person per calendar year deductible for medical services (maximum of 3 medical deductibles per family) <i>AND</i> a separate \$125 per person per calendar year deductible for prescription drugs (maximum of 3 prescription drug deductibles per family).	
Annual Out-of-Pocket Maximum	\$1,200 per person plus the \$125 medical services deductible. Items listed under Other Covered Services are the only expenses that will apply to the annual out-of-pocket maximum.	
PHYSICIAN SERVICES		
Office Visits & Outpatient Consultations Rendered by a Primary Care Physician (includes, Internist, Family & General Practitioner, Pediatrician, OB/GYN & Geriatrician)	Covered at 100% of the allowance, subject to a \$35 office visit co-pay and the medical deductible.	In Alabama: Covered at 60% of the allowance, subject to the medical deductible. Outside Alabama: Covered at 80% of the allowance, subject to the medical deductible.
Office Visits & Outpatient Consultations rendered by a Specialist	Covered at 100% of the allowance, subject to a \$40 office visit co-pay and the medical deductible.	In Alabama: Covered at 60% of the allowance, subject to the medical deductible. Outside Alabama: Covered at 80% of the allowance, subject to the medical deductible.
ER Physician Services	Covered at 100% of the allowance, subject to a \$35 office visit co-pay and the medical deductible.	Covered at 100% of the allowance, subject to a \$35 office visit co-pay and the medical deductible.
Surgery Performed in a Physician's Office	Covered at 100% of the allowance, subject to a \$35 office visit co-pay and the medical deductible if performed by a Primary Care Physician or a \$40 office visit co-pay and the medical deductible if performed by a Specialist.	In Alabama: Covered at 60% of the allowance, subject to the medical deductible. Outside Alabama: Covered at 80% of the allowance, subject to the medical deductible.
Inpatient Visits, Consultations, Surgery & Anesthesia	Covered at 100% of the allowance, subject to the medical deductible.	In Alabama: Covered at 60% of the allowance, subject to the medical deductible. Outside Alabama: Covered at 80% of the allowance, subject to the medical deductible.
Maternity	Covered at 100% of the allowance, subject to the medical deductible.	In Alabama: Covered at 60% of the allowance, subject to the medical deductible. Outside Alabama: Covered at 80% of the allowance, subject to the medical deductible.
Diagnostic X-rays & Lab Exams	Covered at 100% of the allowance, subject to the medical deductible.	In Alabama: Covered at 60% of the allowance, subject to the medical deductible. Outside Alabama: Covered at 80% of the allowance, subject to the medical deductible.
Nurse Practitioner/Nurse Midwife Office Visits & Consultations	Covered at 100% of the allowance, subject to a \$20 office co-pay and the medical deductible. Services must be rendered under the supervision of a doctor.	In Alabama: Not covered. Outside Alabama: Not covered.
INPATIENT HOSPITAL FACILITY SERVICES		
Inpatient Facility Coverage	Covered at 100% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries, subject to a \$350 per admission co-pay and the medical deductible (maximum of 3 inpatient per admission co-pays per person per calendar year); 365 days per confinement.	In Alabama: Not covered unless in cases of medical emergency or accidental injury. Outside Alabama: Covered at 80% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries, subject to a \$350 per admission co-pay and the medical deductible (maximum of 3 inpatient per admission co-pays per person per calendar year); 365 days per confinement.
Preadmission Certification	All hospital admissions except for maternity require preadmission certification. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1-800-248-2342.	

Medical Plan Matrix

(Effective 1-1-2011)



BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
OUTPATIENT HOSPITAL FACILITY SERVICES		
Surgery Facility	Covered at 100% of the allowance, subject to a \$125 facility co-pay and the medical deductible.	Covered at 80% of the allowance, subject to a \$125 facility co-pay and the medical deductible.
Diagnostic Lab, X-ray & Tests	Covered at 100% of the allowance subject to a \$125 facility co-pay and the medical deductible for each of the following: MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, colonoscopy, endoscopy and heart catherizations.	Covered at 80% of the allowance subject to a \$125 facility co-pay and the medical deductible for each of the following: MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, colonoscopy, endoscopy and heart catherizations.
Hemodialysis, Chemo, Radiation & IV Therapy	Covered at 100% of the allowance, subject to the medical deductible.	Covered at 80% of the allowance, subject to the medical deductible.
ER - Medical Emergency	Covered at 100% of the allowance, subject to a \$125 facility co-pay and the medical deductible.	Covered at 100% of the allowance, subject to a \$125 facility co-pay and the medical deductible.
ER - Non-Emergency	Covered at 80% of the allowance, subject to a \$125 facility co-pay and the medical deductible.	Covered at 80% of the allowance, subject to a \$125 facility co-pay and the medical deductible.
ER - Accidental Injury	Covered at 100% of the allowance, subject to a \$125 facility co-pay and the medical deductible.	Covered at 100% of the allowance, subject to a \$125 facility co-pay and the medical deductible.
Note: In Alabama, outpatient benefits for out-of-network hospitals are available only in cases of medical emergency or accidental injury.		
PREVENTIVE CARE SERVICES		
Inpatient Routine Newborn Care	Covered at 100% of the allowance.	Not covered.
Routine Immunizations	100% of the allowance, no deductible or co-pay. See www.bcbsal.com/immunizations for a listing of specific covered immunizations. In addition to the standard immunizations, the following are also covered by this plan: <ul style="list-style-type: none"> • Malaria (when approved) • Cervical cancer vaccine for females age 9 to 26 	Not covered.
Routine Preventive Services	100% of the allowance, no deductible or co-pay. See www.bcbsal.com/preventiveservices for a listing of specific covered preventive services. In addition to the standard services, the following are also covered by this plan: <ul style="list-style-type: none"> • One CBC and one urinalysis each year • TB skin testing – one each year through age 6; one between ages 7 and 18; one between ages 19 and 34 and one age 35 and older • Cholesterol testing (beginning at age 19; once every 5 years) • Thyroid profile (one each calendar year, beginning at age 50) • Routine EKG (one each calendar year, beginning at age 50) • Lead screening, twice before age 4 • SMA 22 lab test (or lesser automated panel test) beginning at age 19, one each calendar year • Chest x-ray beginning at age 35 • CA 125 blood test covered for females • Routine bone density screening (one every two calendar years beginning at age 40) 	Not covered.

Medical Plan Matrix

(Effective 1-1-2011)



BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient Facility Services	Covered at 100% of the allowance, subject to the \$350 inpatient per admission co-pay and the medical deductible. Covers up to 30 days per person each 12 consecutive months (maximum of 3 inpatient per admission co-pays per person per calendar year).	Covered at 80% of the allowance, subject to the \$350 inpatient per admission co-pay and the medical deductible. Covers up to 30 days per person each 12 consecutive months (maximum of 3 inpatient per admission co-pays per person per calendar year).
	Note: In Alabama, inpatient benefits for out-of-network hospitals are available only in cases of medical emergency or accidental injury.	
Inpatient Physician Services	Covered at 100% of the allowance, subject to the medical deductible. Note: Employee is also responsible for any charges above the allowance.	
Outpatient Physician Services	Covered at 100% of the allowance, subject to a \$35 office visit co-pay and the medical deductible. Note: Employee is also responsible for any charges above the allowance.	
Alcohol & Drug Abuse Rehab Benefits	Covered at 100% of the allowance, subject to the medical deductible, in participating substance abuse facilities; residential coverage up to 30 inpatient days in a 12 consecutive month benefit period; lifetime maximum of two benefit periods per member.	
	Note: Benefits available only if services are rendered in the State of Alabama.	
OTHER COVERED SERVICES		
Participating Chiropractor Services	Covered at 80% of the allowance, subject to the medical deductible when services are provided by a participating in-network chiropractor.	In Alabama: Covered at 60% of the allowance, subject to the medical deductible when services are provided by a out-of-network chiropractor. Outside Alabama: Covered at 80% of the allowance, subject to the medical deductible.
	Note: Limited to a maximum of 24 visits per person each calendar year.	
Nutritionist Visits	Covered at 100% of the allowance, subject to a \$20 office visit co-pay and the medical deductible. Limited to a maximum of eight visits per person each calendar year. Note: Employee is also responsible for any charges above the allowance.	
Routine Vision	Covered at 80% of the allowance subject to the medical deductible for one routine eye exam per person each calendar year.	
Physical Therapy	Covered at 80% of the allowance, subject to the medical deductible.	
Speech Therapy	Covered at 80% of the allowance, subject to the medical deductible. Limited to a maximum of 20 visits per person each calendar year.	
Occupational Therapy	Covered at 80% of the allowance, subject to the medical deductible for services related to the hand &/or treatment of lymphedema. Limited to a max. of 20 visits per person each calendar year.	
Durable Medical Equipment	Covered at 80% of the allowance, subject to the medical deductible.	
Ambulance Services	Covered at 80% of the allowance, subject to the medical deductible.	
Preferred Home Health Care	Covered at 100% of the allowance, subject to the medical deductible. Precertification is required for services rendered outside Alabama. Call 1-800-821-7231.	In Alabama: No benefits are available if a non-preferred provider is used. Outside Alabama: Covered at 80% of the allowance, subject to the medical deductible. Precertification is required. Call 1-800-821-7231.
Preferred Hospice Care	Covered at 100% of the allowance, subject to the medical deductible. Precertification is required for services rendered outside Alabama. Call 1-800-821-7231.	In Alabama: No benefits are available if a non-preferred provider is used. Outside Alabama: Covered at 80% of the allowance, subject to the medical deductible. Precertification is required. Call 1-800-821-7231.
Baby Yourself	A benefit that offers the opportunity to have a Blue Cross & Blue Shield of Alabama registered nurse case manager monitor a covered member's pregnancy while enrolled in this medical plan. Note: The \$350 inpatient hospital co-pay per admission will be waived for Baby Yourself participants who enroll within the first trimester of pregnancy and continue participation until the baby is born.	
Air Medical Services	Air ambulance service to a hospital near the member's home if hospitalized while traveling more than 150 miles from home. To arrange transportation, call AirMed at 1-877-872-8624.	

Medical Plan Matrix

(Effective 1-1-2011)



RETAIL PHARMACY					
<ul style="list-style-type: none"> Separate \$125 prescription drug deductible per person per calendar year; maximum of 3 prescription drug deductibles per family. Only one prescription drug deductible will apply if an individual uses a retail pharmacy and/or the mail order program. The first prescription for a drug on the maintenance list allows for a 31-day supply with subsequent refills dispensed in a 60-day supply. Diabetic supplies are only covered through the Drug Card Program; limited to a 60-day supply at a retail pharmacy or a 90-day supply through mail order. Prescription contraceptives are covered subject to the appropriate doctor's office visit or pharmacy co-pay. Insulin, insulin needles & syringes purchased on the same day will require only one co-pay. Blood glucose strips & lancets purchased on the same day will require only one co-pay. Glucose monitors will always require a separate co-pay. 					
IN-NETWORK (PPO) Participating Pharmacy: Prescription drugs will be covered at 100% of the allowed charge after the prescription drug deductible is met & subject to the following co-pays:			OUT-OF-NETWORK (NON-PPO) Non-Participating Pharmacy: Prescription drugs will be covered at 75% of the allowed charge after the prescription drug deductible is met & subject to the following co-pays:		
Type of Drugs	1-31 day supply (available for maintenance & non-maintenance drugs)	32-60 day supply (available only for maintenance drugs)	Type of Drugs	1-31 day supply (available for maintenance & non-maintenance drugs)	32-60 day supply (available only for maintenance drugs)
Generic Drugs	\$15 co-pay	\$30 co-pay	Generic Drugs	\$15 co-pay	\$30 co-pay
Preferred Brand Name Drugs	\$40 co-pay	\$80 co-pay	Preferred Brand Name Drugs	\$40 co-pay	\$80 co-pay
Non-Preferred Brand Name Drugs	\$50 co-pay	\$100 co-pay	Non-Preferred Brand Name Drugs	\$50 co-pay	\$100 co-pay
Brand Name Drugs with a Generic Alternative	\$60 co-pay*	\$120 co-pay*	Brand Name Drugs with a Generic Alternative	\$60 co-pay*	\$120 co-pay*
	* Plus the difference in cost between a brand name drug and its generic drug alternative			* Plus the difference in cost between a brand name drug and its generic drug alternative	
Specialty Drugs	\$120 co-pay	NA	Specialty Drugs	\$120 co-pay	NA
Note: To verify if a drug is on the Preferred Brand Drug List, Maintenance Drug List or Specialty Drug List, call Blue Cross at 1-800-292-8868.					

MAIL ORDER PROGRAM			
<ul style="list-style-type: none"> Separate \$125 prescription drug deductible per person per calendar year; maximum of 3 prescription drug deductibles per family. Only one prescription drug deductible will apply if an individual uses a retail pharmacy and/or the mail order program. Provided through Prime Therapeutics. Enroll online at www.bcbsal.com or call (888) 766-5490. 			
Mail Order Program: Prescription drugs will be covered at 100% of the allowed charge after the deductible & subject to the following co-pays:			
Type of Drugs	1-31 day supply (available for maintenance & non-maintenance drugs)	32-60 day supply (available only for maintenance drugs)	61-90 day supply (available only for maintenance drugs)
Generic Drugs	\$10 co-pay	\$20 co-pay	\$30 co-pay
Preferred Brand Name Drugs	\$30 co-pay	\$60 co-pay	\$90 co-pay
Non-Preferred Brand Name Drugs	\$35 co-pay	\$70 co-pay	\$105 co-pay
Brand Name Drugs with a Generic Alternative	\$50 co-pay*	\$100 co-pay*	\$150 co-pay*
	* Plus the difference in cost between a brand name drug and its generic drug alternative		

This is not a contract. Benefits are subject to the terms, limitations & conditions of the group contract.

PrimeMail® - Mail-Order Prescription Drug Service

PrimeMail® is the mail-order prescription drug service provided by Prime Therapeutics. The mail order service is administered by Blue Cross and Blue Shield and is a convenient way to purchase drugs which are used to treat chronic conditions and are taken for a period of 30 days or longer. You may be taking medication for an extended period of time, but not all medications are considered maintenance medications by the plan.

Any prescription drug may be purchased through mail-order. You are allowed to receive up to a 90 day supply for drugs indicated on the Maintenance Drug List. You can only receive up to a 31 day supply of non-maintenance drugs. You may access the Maintenance Drug List (as well as the Preferred Drug List) at www.bcbsal.com. Choose "Pharmacy" and then select "Prescription Drug Guide and Drug List."

Contact for benefit or eligibility questions

Questions concerning mail-order benefits or eligibility should be directed to PrimeMail® at (800) 391-1886.

Ordering prescriptions or checking order status

To order prescriptions or check the status of an order, contact PrimeMail® at (800) 391-1886. You may also order refills and check the status of an order online at www.bcbsal.com. Choose "Pharmacy" and then select "Mail-Order Pharmacy Services." Sign in and then click on the PrimeMail® logo.

Mail order cost - Applicable co-pays are as follows:

Generic Drugs:

\$10 co-pay for a 1-31 day supply
\$20 co-pay for a 32-60 day supply
\$30 co-pay for a 61-90 day supply

Preferred Brand Name Drugs:

\$30 co-pay for a 1-31 day supply
\$60 co-pay for a 32-60 day supply
\$90 co-pay for a 61-90 day supply

Non-Preferred Brand Name Drugs:

\$35 co-pay for a 1-31 day supply
\$70 co-pay for a 32-60 day supply
\$105 co-pay for a 61-90 day supply

Brand Name Drugs with a Generic alternative:

\$50 co-pay for a 1-31 day supply *
\$100 co-pay for a 32-60 day supply *
\$150 co-pay for a 61-90 day supply *

* Member will also be responsible for the difference in drug cost between brand name drug and generic drug.

Note: A separate \$125 prescription drug deductible per person per calendar year; 3 member family maximum. Prescription drugs will be covered at 100% of the allowed charge after the deductible and subject to the above indicated co-pays:

Receiving mail order prescription drugs

Your prescription will be delivered to you, postage paid by U.S. Mail or other carrier, within *approximately 14 days from receipt of the order*. Prescriptions can be shipped via overnight carrier for an additional charge. If you wish to obtain a brand name drug

when a generic is available, your doctor must write "dispense as written" or "brand necessary" on the prescription. You will be required to pay a higher co-pay when purchasing a brand name when a generic is available. Otherwise, generics will be dispensed when appropriate and permitted by your physician.

Enrolling in the Mail-Order Service

1. Ask your physician to write two prescriptions: one for an initial 30-day supply to be filled by your local pharmacy and one for the maintenance quantity through PrimeMail®, with appropriate refills.

As an alternative, your doctor can fax your prescriptions directly to PrimeMail® using the Physician's Fax Form that can be downloaded at www.bcbsal.com. Choose "Pharmacy" and then select "Mail-Order Pharmacy Services." Sign in and then click the PrimeMail®. Select "Physician's Fax Form."

2. Complete the Mail-Order Form for you and each of your eligible dependents. Additional copies of the form are available at www.bcbsal.com. Choose "Pharmacy" and then select "Mail-Order Pharmacy Services." Sign in, then click on the PrimeMail®. Select "Mail Order Form — PDF version."

3. Mail your Mail-Order Form, original written prescription(s) and payment (check, money order or credit card information) to:
PrimeMail®
P. O. Box 650041
Dallas, TX 75265-0041

Ordering Refills

You can order refills by using one of the following methods at least **two weeks** before your current supply runs out. Be prepared to provide the patient's date of birth, member ID number, prescription number(s) and credit card information.

- **Online** - Go to www.bcbsal.com. Choose "Pharmacy" and then select "Mail-Order Pharmacy Services." Sign in and then click on the PrimeMail® logo. You may be required to register at the PrimeMail® site if you have not already done so. Sign in and click "Refill Prescriptions."
- **By mail** - Complete the mail order form and mail it with your payment.
- **By phone** - Call PrimeMail® at (800) 391-1886 and be prepared to provide the patient's date of birth, your Blue Cross member ID number, prescription number(s) and your credit card information.

No refills left on the Mail Order Prescription

If your prescription label indicates "0" refills or your refill request states "your prescription has expired," please do the following:

- Request a new prescription from your doctor
- Mail your order form, the *original* (not duplicate) written prescription(s) and payment (check, money order or credit card information) to PrimeMail®.

Dental Plan

The University's dental plan is offered through Blue Cross and Blue Shield of Alabama effective 1-1-10. Participants have the freedom to seek care from any licensed dentist, but they will have lower out-of-pocket costs if an in-network Blue Cross and Blue Shield Preferred Dentist is used. An in-network Preferred Dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in-full for services provided to plan participants.

A list of in-network Preferred Dentists is available online at www.bcbsal.com or by calling 1-800-292-8868. Participants who receive services from an in-network Preferred Dentist are only responsible for the difference between the Preferred Dental Fee Schedule and the plan's payment which is based on the dental network fee schedule or the allowed amount. However, those who choose dentists out-of-network, may experience significantly higher out-of-pocket expenses since they will incur balance billing and will be responsible for paying any difference between their dentists' fees and the plan's payment.

Any plan participant whose current dentist does not participate in the Preferred Dental Network can encourage him or her to apply for membership, by visiting the dental professional website at www.bcbsal.org/providers/dentists.cfm or calling 1-800-373-4879 for an application.

Customer Service Center:

1-800-292-8868

Find an in-network Preferred Dentist:

www.bcbsal.com or call

1-800-292-8868

Customer Service Hours

Mon - Fri from 7:30 a.m. to 6:00 p.m. CT

Note: This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

Version 12-11-09

GENERAL PROVISIONS	
Deductible	\$50 deductible per member per calendar year; \$150 aggregate family maximum.
Annual Dental Maximum	Combined in and out-of-network maximum of \$1,000 per member each calendar year. Additional \$500 benefit available if services are received in-network.
Lifetime Orthodontic Maximum	\$1,000 lifetime maximum per person.
Waiting Period	12 month waiting period for new entrants into the plan for Restorative (except fillings and simple extractions), Supplemental, Periodontic, Prosthetic and Orthodontic services. The waiting period will be waived for those new entrants with proof of prior coverage and no more than a 63 day break in that coverage.
DIAGNOSTIC AND PREVENTIVE (Exams and Cleanings)	
<p>Covered at 100% of the allowed amount, no deductible. Includes:</p> <ul style="list-style-type: none"> Dental exams up to twice per benefit period. Full mouth x-rays, one set during any 36 consecutive months. Bitewing x-rays, one set per benefit period. Other dental x-rays, used to diagnose a specific condition. Routine cleanings, twice per benefit period. Tooth sealants on teeth numbers 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of \$20 per tooth. Limited to the first permanent molars of children through age 13. Fluoride treatment for children under age 19 twice per benefit period. Space maintainers (not made of precious metals) that replace prematurely lost teeth for children under age 17. 	
RESTORATIVE (Fillings and Root Canals)	
<p>Covered at 80% of the allowed amount, subject to the deductible. Includes:</p> <ul style="list-style-type: none"> Fillings made of silver amalgam and synthetic tooth color materials on teeth numbers 5-12 and 21-28. Simple tooth extractions. Direct pulp capping, removal of pulp and root canal treatment. Repairs to removable dentures. Emergency treatment for pain. 	
SUPPLEMENTAL (Oral Surgery and Anesthesia)	
<p>Covered at 80% of the allowed amount, subject to the deductible. Includes:</p> <ul style="list-style-type: none"> Oral surgery for tooth extractions and impacted teeth. General anesthesia given for oral or dental surgery. This means drugs injected, inhaled for relaxation, to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide. Treatment of the root tip of the tooth including its removal. 	
PERIODONTIC (Gum Disease)	
<p>Covered at 80% of the allowed amount, subject to the deductible. Includes:</p> <ul style="list-style-type: none"> Periodontic exams twice each 12 months. Removal of diseased gum tissue and reconstructing gums. Removal of diseased bone. Reconstruction of gums and mucous membranes by surgery. Removing plaque and calculus below the gum line for periodontal disease per quadrant every two years. Periodontal surgery once per quadrant, every three years. 	
PROSTHETIC (Crowns and Dentures)	
<p>Covered at 50% of the allowed amount, subject to the deductible. Includes:</p> <ul style="list-style-type: none"> Full or partial dentures. Fixed or removable bridges. Inlays, onlays, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings are not adequate. 	
ORTHODONTIC (Braces)	
<p>Covered at 50%, no deductible.</p> <ul style="list-style-type: none"> Limited to a lifetime maximum of \$1,000. For dependent children up to the end of the month of their 19th birthday. 	

Vision Plan

The University offers eligible employees a vision plan through UnitedHealthcare Vision (UHC Vision) which offers members access to a nationwide network of over 30,000 private practices and retail chain locations. Members can get a complete eye exam and new eyeglass lenses every 12 months. New eyeglass frames are covered every 24 months. UHC Vision providers have a wide selection of frames that are available for a small co-pay only. Participants can also choose frames from outside the UHC Vision collection and get a generous frame allowance. Those who prefer contact lenses can have an eye exam and a supply of contacts each year. The following is a summary of the plan benefits:

In-Network Benefits

Comprehensive Vision Exam

A comprehensive eye examination from a UHC Vision network optometrist or ophthalmologist is covered once every 12 months at 100% after a \$10 co-pay.

Materials

The plan's \$20 materials co-pay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses. After the co-pay, the plan provides these benefits:

Lenses – once every 12 months

- One pair of standard single vision, lined bifocal, lined trifocal or standard lenticular lenses for eyeglasses is covered at 100%.
- Standard scratch-resistant coating and polycarbonate lenses are covered at 100%.
- Progressive lenses, tints, UV and anti-reflective coating may be available at a discount

Frames – once every 24 months

Members have two frame options to choose from:

- Select frames from the UHC Vision frame collection covered at 100%, or receive a \$130 frame allowance at private practice providers.
- Utilize a \$130 frame allowance at any of the retail practice providers.

Laser Vision Correction – UHC Vision participants receive discounts from participating laser vision correction providers. To find a nearby participating laser vision correction surgeon, go to www.myuhcvision.com, or call 1-877-28-SIGHT.

Contact Lenses in Lieu of Eyeglasses – once every 12 months

- Covered-in-full elective contact lenses – The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered at 100% (after the materials co-pay) for many of the most popular brands on the market. If covered disposable contact lenses are chosen, up to 6 boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UHC Vision's covered-in-full contact lenses may vary by provider.
- All other elective contacts – A \$150 allowance applies toward the fitting/evaluation fees and purchase of contact lenses

outside of UHC Vision's covered-in-full contacts (materials co-pay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of UHC Vision's covered-in-full selection.

- Medically Necessary contact lenses – Covered-in-full (after materials co-pay). Medically necessary contact lenses are used to treat specific conditions as determined by eye care providers. Participants with conditions warranting medically necessary contacts should ask their providers to contact UHC Vision concerning the reimbursement that UHC Vision will make before they purchase such contacts.

Out-of-Network Benefits Schedule

If a non-network provider is used, the plan will reimburse up to:

Exam (once every 12 months)	
Optometrist	\$40
Ophthalmologist	\$40
Lenses (once every 12 months)	
Single vision	\$40
Bifocal	\$60
Trifocal	\$80
Lenticular	\$80
Frames (once every 24 months)	
Contact Lenses (in lieu of spectacle lenses and frames)	
Medically Necessary	\$210
Elective	\$150

Out-of-Network Reimbursement

If a non-network provider is used, itemized paid receipts, with the primary insured's Social Security number, patient's name and patient's date of birth must be sent to:

UnitedHealthcare Vision
P. O. Box 30978
Salt Lake City, UT 84130
Attention: Claims Department

Please note: Receipts for services and materials purchased on different dates must all be submitted at the same time to receive reimbursement. **UHC Vision will reimburse you according to the schedule.**

How To Use the UHC Vision Plan

Step 1 - Review the Benefits Materials

Carefully review this material to understand the plan design and applicable co-pays.

Step 2 - Find a Provider

Locate a provider by logging on to www.myuhcvision.com and selecting the provider locator option. Participants may also contact UHC Vision's 24-hour, toll-free Interactive Voice Response system at 1-800-839-3242 to locate a nearby provider.

Step 3 - Schedule an Appointment

Once a provider has been chosen, simply call the provider directly to schedule an appointment. Provide the primary insured's social security number, the patient's name and date of birth, and state that UHC Vision Plan coverage is in effect.

Step 4 - Receive an Eye Exam

The network provider, a state-licensed optometrist or ophthalmologist, will perform a complete eye examination, including a case history of the patient, an examination for eye pathology and abnormalities, visual analysis (refraction), confrontation visual fields testing, condition diagnosis, and prescription determination.

Step 5 - Choose Eyewear

If prescription eyewear is necessary, the UHC Vision provider will write a prescription, assist with eyewear selection and order the eyewear. The UHC Vision provider will telephone the participant when the eyewear arrives. Eyewear is dispensed at the provider's office to ensure optical accuracy and proper fit.

Important Items to Remember

- A UHC Vision ID card will not be issued. Participants merely identify themselves as UHC Vision members when making appointments. This assists providers in obtaining claim authorizations prior to patients' visits.
- For those that may wish to have an ID card, you can now go to the website www.myuhcvision.com and print ID cards for yourself and your dependents. For dependents, enter your member ID and then enter the dependents last name and date of birth. The card will print with the dependent's information listed.
- Benefits are available every 12 or 24 months based on last date of service.
- Contact lenses are in lieu of lenses and frame. Providers will help determine which contact lenses are covered under the plan.
- The \$150 contact lens allowance applies to the fitting/evaluation fee as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30, the participant will have \$120 towards the purchase of contact lenses. At some retail chain locations the allowance may be shared between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of the covered-in-full selection.
- The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Workers'

Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or material that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

If you have any questions or concerns about your vision options, please contact UHC Vision's:

Customer Service Center:

1-800-638-3120 or TDD 1-800-524-3157 for the hearing impaired.

Customer Service Hours:

Mon – Fri from 7:00 a.m. to 10:00 p.m. CT

Sat from 8:00 a.m. to 5:30 p.m. CT

www.myuhcvision.com

Please Note: This summary provides an overview of the benefits. If there are any differences between this document and the Group Policy, the Group Policy is the governing document. Specific plan details can be viewed via the internet at <http://hr.ua.edu/benefits/index.html>.

Flexible Spending Accounts (FSA)

An FSA is a voluntary program that allows you to pay for a variety of out-of-pocket healthcare and/or dependent care expenses through pre-tax payroll deductions. Flexible Corporate Plans (FLEXCORP) is the FSA administrator for the University. When enrolling, you determine how much money you want to contribute to each account. The money is then withheld from your pay before taxes are calculated providing you with more value for your dollar. FSA participants will be able to use a special debit MasterCard® to pay their eligible FSA expenses. You will also be able to manually file for reimbursement from your account. The University provides two types of FSAs:

Healthcare Flexible Spending Account (HFSA)

This account can be used to pay for many healthcare expenses incurred by you and eligible IRS tax dependents that are not covered by your medical, dental or vision insurance. The maximum annual amount allowed for this plan is \$8,000. Some common eligible expenses include orthodontia, coinsurance, co-pays, prescriptions and some over-the-counter medications (if prescribed by a physician).

To be considered eligible for reimbursement, healthcare expenses cannot be paid by or reimbursed through any benefit plan. You may be reimbursed your full HFSA annual election amount prior to having the full amount of payroll contributions deducted and deposited in your account. You do not have to enroll in a medical plan to participate in the HFSA.

Dependent Care Flexible Spending Account (DCFSA)

This account can be used to reimburse you for expenses associated with the care of your qualified IRS dependents, as long as the expenses are incurred:

- so you and your spouse can work or attend school full-time
- for services relating to the care of a dependent child under the age of 13 or your dependent or spouse who is physically or mentally incapable of self-care and who lives with you for more than one-half of the year
- for services provided during the plan year while employed with the University.

The maximum annual amount allowed for this plan is \$5,000 or \$2,500 for married taxpayers filing separate returns.

Reimbursements from the DCFSA cannot exceed the amount deposited in your account at the time your reimbursement is processed. Eligible expenses include:

- licensed nursery school and daycare facilities for children
- child care in or outside your home
- day care for an elderly disabled dependent

There are other tax considerations you must weigh when making decisions about this account, such as the Child Care Tax Credit.

The IRS allows you to take a credit on your federal income taxes for your work-related dependent day care expenses if you file an itemized return. Depending on your income and tax filing status, this Child Care Tax Credit may offer more, or less, tax savings

than the DCFSA. You can use both the tax credit and the DCFSA (not for the same expenses), but any tax credit you take reduces the amount you can contribute to, and claim from, the account. Only you can decide which method is best for your situation.

Eligible FSA Expenses

You can obtain a detailed list of eligible and ineligible expenses for both accounts by accessing www.irs.gov. Under "Forms and Publications," enter "502" for the healthcare plan and "503" for the dependent care plan.

Using This Benefit

You must enroll and indicate how much to contribute within the first 30 days of hire, within 30 days after a qualifying event or during the annual open enrollment period. The amount you elect will be deducted from your pay in equal amounts depending on your pay schedule. After you enroll, you will receive a welcome letter from FLEXCORP with information about your account.

Getting Reimbursed

Healthcare Expenses – If your medical, dental and/or vision coverage is provided by the University, your and any covered dependents' eligible out-of-pocket expenses will automatically apply to your account. If your medical, dental or vision insurance is provided through another employer, or you are filing for eligible over-the-counter expenses, you must file a Request for Reimbursement form with the appropriate documentation with FLEXCORP.

Dependent Care Expenses – You will need to file a Request for Reimbursement Preferred Health FSA form with the appropriate documentation with FLEXCORP in order to be reimbursed.

Tax Savings Examples

Participating in an FSA can reduce your taxes by reducing your taxable income. Using these pre-tax accounts can make a significant difference in your take-home pay. The chart below illustrates what would happen if your annual pay was \$45,000 and you had \$2,000 in eligible health or dependent care expenses.

Example	Without FSA	With FSA
Annual pay	\$45,000	\$45,000
FSA Pre-tax contribution	0	- 2,000
Estimated taxes	- 6,043	- 5,590
Out-of-pocket expenses	- 2,000	0
Take-home pay	\$36,957	\$37,410
Extra take-home pay with FSA		\$453

Important Facts to Remember

- You cannot change the amount to be contributed to your FSA during the year unless you experience a qualifying event and then you must make any changes within 30 days of the qualifying event.
- Any amounts remaining in your FSAs not **incurred** by December 31st will be forfeited, as required by the IRS.
- Your Social Security benefits may be reduced by this election.
- You cannot use funds from one FSA account to pay for expenses that apply to the other FSA account.

FSA Eligible Healthcare Expenses

Healthcare expenses that are deductible under the Internal Revenue Code and not covered by insurance or any other source that provides benefits are usually eligible for reimbursement through the Healthcare FSA. The exception to this is expenses for cosmetic procedures, expenses incurred for general health and well being and health insurance premiums.

Some over-the-counter medications and supplies are allowed, but may require a prescription from a physician. The receipt for over-the-counter medications must clearly indicate the name of the item purchased.

Following is a partial listing of eligible and ineligible healthcare expenses:

<p>Eligible Healthcare Expenses</p> <ul style="list-style-type: none"> • Alcoholism, treatment of • Acupuncture • Ambulance • Artificial limb & teeth • Automobile equipment to assist the physically disabled • Bandages • Birth control items prescribed by your doctor • Birth control pills • Braille books and magazines • Childbirth preparation classes • Chiropractic expenses • Coinsurance • Contact lenses • Contact lens cleaning solution • Co-payments • Cost of a note-taker for a hearing impaired child in school • Cost of guide or guide dogs for persons who are visually or hearing impaired • Counseling (individual, family & group) • Crutches • Deductibles for medical, dental, and vision plans • Dental treatment • Denture Adhesives • Detoxification or drug abuse centers • Diabetic supplies • Expenses for services connected with donating an organ • Expenses in excess of medical, dental, or vision plan limits • Eye exams • Eyeglasses (including reading glasses) • First aid kits • First aid spray • Hearing aids • Household visual alert system for hearing impaired persons • Hypnosis-treatment for a diagnosed condition • Laser eye surgery • Massage therapy (<i>if prescribed by a physician to treat a specific medical condition</i>) • Nebulizer • Nicotine patches and gum • Orthodontia • Ostomy products • Routine gynecological exams • Routine physical exams • Well-baby and well-child care • Orthopedic shoes • Physical therapy • Prescription drugs • Psychotherapy • Radiation treatments 	<ul style="list-style-type: none"> • Specialized equipment for disabled persons • Special devices, such as a tape recorder and typewriter, for persons who are visually impaired • Speech therapy • Sterilization surgery • Transportation expenses related to medical care • Weight reduction program for physician diagnosed obesity • Wheelchairs • Wigs for hair loss due to any disease (must have doctor's certification) • X-rays <p>Eligible Over-the-Counter Expenses (with prescription)</p> <ul style="list-style-type: none"> • Allergy and asthma medicines • Allergy eye drops • Antibiotic cream • Bug-bite medication • Calamine lotion • Cold/hot packs for injuries • Cortisone cream • Cough, cold, and flu • Nasal sinus sprays • Nicotine gum or patches (for stop-smoking purposes) • Pain relievers - topical creams and oral medicines • Rubbing alcohol • Special ointment or cream specifically for burns • Suppositories and cream for hemorrhoids • Throat lozenges <p>Ineligible Expenses</p> <ul style="list-style-type: none"> • Dietary supplements not considered a medical necessity • Face cream, moisturizers, • Make-up, lipstick, eye-cream • One-a-day vitamins • Perfume, body sprays, deodorants • Protein bars • Shampoos and soaps • Suntan lotion • Teeth whitening procedures • Toothpaste, toothbrushes, dental floss
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FSA Worksheet

Use this worksheet to help calculate your eligible FSA expenses. This is not an all-inclusive list of eligible expenses, but it contains some of the most common ones. Identify the amounts you spent last year, adjust the expenses based on your future health care needs and enter the amounts in the spaces below. Remember, to be eligible for reimbursement, incurred expenses cannot be reimbursed from another source, e.g., the UA Medical Plan. It is your responsibility to be sure that expenses qualify for reimbursement. Call FLEXCORP at 888-505-4557 to ensure that your anticipated expenses qualify for reimbursement. After an election is made, it cannot be revised or revoked unless you experience a qualified family status change.

ANTICIPATED MEDICAL EXPENSES – not reimbursed by your medical insurance	Cost Estimate
1. Co-pays (<i>office visit/prescription co-pay amounts x number of anticipated visits/prescriptions</i>)	\$
2. Deductibles (<i>for you and eligible dependents</i>)	\$
3. Coinsurance amount (<i>e.g., 20% of the services after deductible</i>)	\$
4. Routine exam (<i>annual physical, yearly exams, well-baby</i>)	\$
5. Hearing care expenses (<i>hearing aids, exams, etc.</i>)	\$
6. Prescription drugs (<i>not covered by insurance</i>)	\$
7. Eligible over-the-counter medications (<i>may require prescription</i>)	\$
8. Alternative care (<i>chiropractor, acupuncture office visits</i>)	\$
9. Weight loss program (<i>must submit a letter from doctor regarding medical condition</i>)	\$
10. Massage Therapy (<i>must submit a letter from doctor regarding medical condition</i>)	\$
11. Other anticipated qualified expenses not listed	\$
Sub Total	\$

ANTICIPATED DENTAL EXPENSES – not reimbursed by your dental insurance	Cost Estimate
1. Deductibles (<i>for you and eligible dependents</i>)	\$
2. Coinsurance amount (<i>e.g., 20%, 50% of services after deductible</i>)	\$
3. Examinations, cleanings, fluoride treatments, x-rays, space maintainers, sealants	\$
4. Fillings, extractions, root canals, denture repairs	\$
5. Crowns, inlays, onlays, bridges, dentures	\$
6. Orthodontia treatment	\$
7. Other anticipated qualified dental expenses not listed	\$
Sub Total	\$

ANTICIPATED VISION EXPENSES – not reimbursed by your vision insurance	Cost Estimate
1. Deductibles (<i>for you and eligible dependents</i>)	\$
2. Co-pays (<i>exam and material co-pays x number of visits</i>)	\$
3. Vision examinations	\$
4. Frames, lenses, contact lenses	\$
5. Laser vision correction procedures	\$
6. Other anticipated qualified vision expenses not listed	\$
Sub Total	\$

Total Anticipated Annual Medical, Dental & Vision Expenses (enter amount on FSA Election Form)

\$

ANTICIPATED DEPENDENT CARE EXPENSES	Cost Estimate
1. Dependent care center fees (<i>qualifying child or adult day care</i>)	\$
2. Licensed nursery school fees	\$
3. Other anticipated eligible dependent care expenses	\$

Total Anticipated Annual Dependent Care Expenses (enter amount on FSA Election Form)

\$

University-Paid Group Term Life and Accidental Death & Dismemberment

The University provides eligible employees Group Term Life insurance and Accidental Death & Dismemberment insurance from MetLife. The University pays the full cost for this coverage.

Group Term Life Insurance

Group Term Life coverage pays your beneficiary a designated amount upon your death. The amount varies with annual salary as follows:

<i>Annual Base Salary</i>	<i>Coverage Amounts</i>
Up to \$11,999	\$22,500
\$12,000 to \$17,999	\$25,200
\$18,000 to \$23,999	\$30,000
\$24,000 to \$29,999	\$37,500
\$30,000 to \$39,999	\$50,000
> \$40,000	125% salary (\$300,000 maximum benefit)

The amount of your insurance decreases to 65% once you reach age 65. Once you reach your 70th birthday, your coverage decreases to 50% of the amount in effect on the day before your 65th birthday.

The Group Term Life coverage comes with a special feature called Accelerated Benefit Option. This option allows you to access up to 80% of your group term life insurance proceeds to a maximum of \$240,000 should you become terminally ill and are diagnosed with less than twelve months to live.

Accidental Death & Dismemberment Insurance (AD&D)

The AD&D insurance pays \$22,500 if death was caused by an accident. In instances where death was caused by an accident, your beneficiary would receive both the group term life *and* AD&D benefit.

AD&D also pays a benefit if a serious injury results in dismemberment. For example, if you lose a limb or the ability to see, you may be paid a part of your benefit.

The AD&D coverage includes Travel Assistance Services. This service provides you and your dependents with medical, travel, legal and financial assistance services when faced with an emergency while traveling more than 100 miles away from home. Travel Assistance services are provided and administered by AXA Assistance USA, Inc., and are separate and apart from the insurance provided by MetLife.

When Employment Ends

Should you terminate employment with the University, you can continue your Group Term Life coverage. You must apply and pay for coverage within 31 days after your coverage ends. Coverage continuation is subject to plan design and state availability so contact the HR Service Center at 348-7732 for more details.

University-Paid Long Term Disability

The University provides at no cost to eligible employees Long Term Disability (LTD) insurance through The Standard.

Benefit Amount

Your LTD coverage provides income replacement after a 90-day waiting period if you are unable to return to work due to a non-work related injury or illness. LTD benefits are not payable during the 90-day waiting period.

If your claim is approved by The Standard, benefits are payable on the 91st day from the date of disability. Your monthly benefit is 66 2/3% of your current salary not to exceed \$10,000 per month for the first 90 days. After 90 days of benefit payments, the plan changes from 66 2/3% to 60% of your insured pre-disability earnings reduced by deductible income and continues.

Definition of Disability

You are considered disabled and eligible for benefits if, after the waiting period and the 24-month own occupation period, you continue to meet the definition of disability under the plan.

Maximum Benefit Period

If you become disabled before age 62, LTD benefits may continue during disability until you reach age 65. If you become disabled at age 62 or older, the benefit duration is determined by your age when disability begins:

<i>Age</i>	<i>Maximum Benefit Period</i>
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

When Benefits End

LTD Benefits end automatically on the earliest of:

- The date you are no longer disabled.
- The date your maximum benefit period ends.
- The date you die.
- The date benefits become payable under any other LTD plan under which you become insured through employment during a period of temporary recovery.
- The date you fail to provide proof of continued disability and entitlement to benefits.

Voluntary Group Term Life and Accidental Death & Dismemberment Insurance

The University provides eligible employees the opportunity to purchase additional Group Term Life insurance and Accidental Death and Dismemberment (AD&D) insurance through MetLife. Additional coverage can help defray the loss of income and help your family maintain the household in the event of your death. You have the option of choosing your coverage amount and obtaining coverage for your spouse and dependent children. New employees can enroll in the plan during their first 60 days of employment with no medical questions.

Features of Voluntary Term Life Policy Will Preparation Service

You will have access to a participating plan attorney who will prepare or update wills for you and your spouse at no additional cost to you.

Accelerated Benefits Option

You can receive up to 80% of your Voluntary Life insurance coverage amount to a maximum of \$500,000 in the event that you become terminally ill and are diagnosed with less than 12 months to live.

Waiver of Premiums for Disability

Your life insurance coverage can be continued at no cost to you should you become unable to work due to total disability.

Features of Voluntary AD&D Policy Coverage Amounts for You

Eligible employees can elect Voluntary AD&D insurance in increments of \$25,000. The maximum amount of coverage you can receive is the lesser of 10 times earnings and \$500,000.

Coverage for Your Spouse and Children

You can choose coverage for yourself, your spouse and/or your dependent children under the Family Plan.

If you cover your Spouse and Dependent Child(ren):

Spouse - Covered at 40% of your coverage amount

Child(ren) - 10% of your coverage amount

If you cover Spouse only - 50% of your coverage amount

If you cover Child(ren) only - 15% of your coverage amount

How To Enroll

You have two options for enrollment in Voluntary Group Term Life and AD&D Insurance:

Option 1 - Enroll for insurance coverage quickly and securely online using the "My Benefits" website from MetLife. Just go to www.metlife.com/mybenefits to evaluate your insurance options and complete the enrollment process.

Option 2 - You can request a brochure and enrollment forms from MetLife. Complete the enrollment forms and mail them directly to the MetLife address provided.

Voluntary Term Life Insurance Coverage Options

For You	1 to 5 times your basic annual earnings (BAE) or, in \$50,000 increments, to the lesser of 5 times BAE and \$1,400,000
For Your Spouse	\$10,000 increments, to the lesser of employee's voluntary Life amount and \$150,000
For Your Dependent Children	\$1,000 for children 15 days to 6 months \$10,000 for children 6 months and older

Monthly Cost for Voluntary Term Life Insurance

Employee's Age	Monthly Cost per \$1,000 of Employee coverage	Monthly Cost per \$1,000 of Spouse coverage
Under 25	\$0.036	\$0.036
25 - 29	\$0.045	\$0.045
30 - 34	\$0.054	\$0.054
35 - 39	\$0.071	\$0.071
40 - 44	\$0.091	\$0.091
45 - 49	\$0.136	\$0.136
50 - 54	\$0.208	\$0.208
55 - 59	\$0.359	\$0.359
60 - 64	\$0.553	\$0.553
65 - 69	\$0.993	\$0.993
70 +	\$1.722	\$1.722
Cost for all of your eligible Children		\$1.00 per month

Monthly Cost for Voluntary AD&D Insurance

Voluntary AD&D Benefit Amount	Monthly Cost Employee Only Plan \$0.014 per \$1,000	Monthly Cost Family Plan \$0.019 per \$1,000
\$25,000	\$0.35	\$0.48
\$50,000	\$0.70	\$0.95
\$75,000	\$1.05	\$1.43
\$100,000	\$1.40	\$1.90
\$125,000	\$1.75	\$2.38
\$150,000	\$2.10	\$2.85
\$175,000	\$2.45	\$3.33
\$200,000	\$2.80	\$3.80
\$225,000	\$3.15	\$4.28
\$250,000	\$3.50	\$4.75
\$275,000	\$3.85	\$5.23
\$300,000	\$4.20	\$5.70
\$350,000	\$4.90	\$6.65
\$400,000	\$5.60	\$7.60
\$450,000	\$6.30	\$8.55
Max \$500,000	\$7.00	\$9.50

Retirement Plans

The University of Alabama offers eligible employees a variety of retirement savings plans in order to help provide financial security during retirement. Eligible employees have three plans from which to choose – one mandated plan and two voluntary plans.

Teachers' Retirement System (TRS) – 401(a)

The Teachers' Retirement System plan is a defined benefit retirement plan governed by Internal Revenue Code 401(a). The 401(a) plan is mandated by the state and all eligible employees are required by law to contribute 7.25% of their gross annual salary to the Teachers' Retirement System. The 401(a) plan provides retired employees with a specific benefit payable monthly for the lifetime of the member. In addition to the employee contribution, the University contributes a percentage which is determined by the Alabama Legislature.

TRS members are eligible for retirement benefits at age 60 with 10 years of participating service, or at any age with 25 years of participating service. Accumulated sick leave at retirement may be converted to additional service credit. Upon service retirement, employees are also eligible to join the state's Public Education Employee Health Insurance Plan (PEEHIP). Rates for this plan vary based on years of TRS service.

Individuals who separate from employment before vesting in the program, or before qualifying to receive benefits, may request a refund of their contributions and applicable interest.

University of Alabama System 403(b) Plan

The University of Alabama System 403(b) Plan is a voluntary retirement savings plan that is governed by Internal Revenue Code 403(b). TIAA-CREF and VALIC are the two vendors currently offering 403(b) accounts to University employees. The University's 403(b) plan allows eligible employees to invest in mutual funds. Most employee contributions are made on a pre-tax basis and accumulate tax-free until withdrawal, but Roth post-tax contributions are available.

The University makes a matching contribution for all regular full-time faculty and exempt staff contributions up to 5% of gross monthly pay to TIAA-CREF and VALIC accounts. Additional contributions beyond 5% are encouraged, but are not matched by the University.

Employees may enroll online through Retirement Manager at <http://hr.ua.edu/benefits/HRretirementmanager.html> or by contacting the TIAA-CREF or VALIC representatives.

University of Alabama 457(b) Plans

The University of Alabama's 457(b) plans are voluntary deferred compensation plans governed by Internal Revenue Code 457(b). The Retirement Systems of Alabama, TIAA-CREF and VALIC are the three service providers currently offering 457(b) accounts to University employees. The University's 457(b) plans allow eligible employees to defer receipt of a portion of their salary until some later date, usually at retirement or termination of employment. Most employee contributions are made on a

pre-tax basis and accumulate tax-free until withdrawal, but Roth post-tax contributions are available through TIAA-CREF and VALIC.

Employees may enroll online through Retirement Manager at <http://hr.ua.edu/benefits/HRretirementmanager.html> or by contacting the TIAA-CREF or VALIC representatives.

Key Points for 403(b) and 457(b) Plans

- The 457(b) plan is a retirement savings plan that functions much like the 403(b) plan -- it provides an additional opportunity to set aside retirement monies that can be deferred from federal and state taxes.
- For calendar year 2012, the maximum that can be contributed to the 403(b) plan is \$17,000. Participants who are age 50 or above in 2012, are eligible for an additional \$5,500 catch-up contribution, for a total of \$22,500.
- Participants can contribute a total of \$17,000 using a combination of pre-tax and Roth post-tax contributions to both plans in 2012. (Participants age 50+ can contribute \$22,500.)
- The 457(b) maximums are the same as the 403(b) maximums.
- Employees may participate in both 403(b) and 457(b) plans in the same year. So, participants could contribute as much as \$17,000 to each plan, or \$34,000 total in 2012. For employees who have reached age 50, the maximum would be \$22,500 to each plan, or \$45,000 total in 2012.
- The University's 403(b) and 457(b) plans accept both pre-tax and Roth post-tax contributions.
- Since the University's 403(b) and the 457(b) are retirement savings plans, they both have certain restrictions on withdrawals before retirement age.
- The 457(b) plan does not contain the early retirement withdrawal penalty applicable to the 403(b) plan for someone who separates from employment under age 59 1/2 and wishes to withdraw their accumulation.
- The University will match contributions up to 5% made to the 403(b) plan through TIAA-CREF and VALIC. University matching contributions cannot be directed to the 457(b) Plan.
- The 457(b) plan might work better for someone who wants to contribute substantially more as s/he nears retirement, because of the more generous catch-up provisions. The 457(b) plan provides additional catch-up provisions for participants who are nearing retirement age and want to save even more.

Educational Benefit Program

The University of Alabama offers educational benefits to eligible employees.

Who is eligible?

- All regular (not temporary) full-time and part-time employees
- Spouses, sponsored adult dependents, child dependents and sponsored child dependents after the employee completes 6 months of continuous eligible employment
- All University retirees and the spouses, sponsored adult dependents, child dependents and sponsored child dependents of retirees (if eligible on last day before retirement)

What is covered for employees?

- **Full-time employees** - The educational benefit provides eligible full-time employees an amount to assist with educational costs equal to 100% of the tuition costs for up to three (3) credit hours during the fall and spring semesters and up to six (6) credit hours during the summer term at the standard on-campus in-state tuition rate. All other hours taken will result in assistance at an amount equal to 50% of the tuition costs at the standard on-campus in-state tuition rate. The applicable rate is based on the classification of the enrolled student; i.e. undergraduate, graduate, law or medical.
- **Part-time employees** - Eligible part-time employees will receive a prorated amount of educational assistance based upon their full-time equivalency (FTE). For example: an eligible part-time employee of .50 FTE would be eligible for an amount equal to 50% of the tuition costs for up to three (3) credit hours in the fall and spring semesters and for 50% for up to six (6) credit hours in the summer term, and for 25% for all other credit hours at the standard on-campus in-state tuition rate. The applicable rate is based on the enrolled student's classification; i.e. undergraduate, graduate, law or medical.

What is covered for employee dependents?

- **Spouses, sponsored adult dependents, child dependents and sponsored child dependents** - After eligible employees have been employed six (6) continuous months, covered dependents may receive an amount to assist with educational costs equal to 50% of the tuition costs at the standard on-campus in-state tuition rate for eligible courses. The applicable rate is based on the classification of the enrolled student; i.e. undergraduate, graduate, law or medical. Higher tuition rates for special enrollment programs do not entitle the covered dependents to amounts above the standard on-campus in-state tuition rate. If the sponsoring employee is a regular part-time employee this benefit is prorated based on the employee's FTE. Child dependents and sponsored child dependents must be unmarried and under age 26 on the first day of classes.

How do I apply?

1. All applicants must obtain admission to The University of Alabama in accordance with usual academic rules. You may contact the Office of Admissions for assistance with this process.
2. Applicants should complete and submit a tuition grant application to the **HR Service Center (Box 870174)** at least one month prior to the beginning of the academic year.
 - Applications are available in the HR Service Center or on the HR website:
<http://hr.ua.edu/benefits/documents/Tuitiongrant1106.doc>
 - Employee - complete sections I and III of the application
 - Eligible dependent s - complete sections I, II, and III of the application
 - Only one application per student is necessary for the academic year which begins with the fall semester and ends with the summer term
3. Eligible employees and dependents will receive the benefit as a credit applied to the enrolled student's account maintained by the Office of Student Receivables.

Things to remember:

- The employee must be in an eligible employment status through the first day of classes to receive an educational benefit for the fall semester, spring semester or summer terms. If it is later determined that the employee was not eligible, the educational benefit will be recalled and the appropriate charges will be billed to the employee's student account. Employees are responsible for notifying the HR Service Center of any information that would affect eligibility for the educational benefit.
- If the employee terminates employment with the University or a dependent becomes ineligible during the course of the term, the educational benefit will remain in effect for the remainder of that term only.
- Course related fees, such as laboratory or engineering equipment fees, etc. are not covered by this policy and must be paid by the student.
- This educational benefit applies to The University of Alabama only. The University does not have a reciprocity agreement with The University of Alabama at Birmingham or The University of Alabama in Huntsville.
- Educational benefits may have withholding tax implications. Educational benefits received by dependents and sponsored dependents of University employees are almost always taxable to the employee if the eligible dependent is enrolled in graduate school. For those educational benefits which are taxable, Federal, State and Social Security taxes will be withheld from the employee's payroll checks at the end of the semester in which the dependent was enrolled and received an educational benefit. This will usually occur in May for the spring semester, August for the summer terms, and November for the fall semester.

WellBama

WellBama is The University of Alabama's signature wellness program for faculty and staff. Designed to promote health and improve the quality of life for all employees, this free, personalized program includes confidential health screening, health coaching, and a preventive examination, along with a wide range of resources and programs to motivate and support individual health goals.

Participation

The Office of Health Promotion administers WellBama and Wellness (OHPW) with services coordinated with partners from the College of Community Health Sciences and the College of Capstone Nursing. Participation in the WellBama program is voluntary, yet strongly encouraged.

Enrollment in WellBama is offered at specific times, dates and locations for each department or college, with full details listed at www.wellness.ua.edu or contact the office at 205-348-0077.

Health Screening

Screening by qualified health professionals takes approximately 30 minutes. Body measurements, blood pressure and a health history are taken, in addition to lab work to evaluate current cholesterol, glucose, and triglyceride levels. (To ensure accurate results, participants should not eat food ten hours prior to testing.)

Health Coaching

Immediately following screening, participants meet with a WellBama health coach to review their results and discuss their concerns. Coaches assist participants in developing personalized strategies to meet their goals. With a focus on fitness, nutrition, and life balance, coaches help to create a customized plan for optimal health and wellness. Tip sheets and other information are also offered.

Physical Exam

Following health screening and coaching, WellBama participants are eligible to schedule a free, comprehensive preventive physical exam at the Faculty Staff Wellness Clinic. Located in the University Medical Center, the Wellness Clinic is staffed by Board Certified Nurse Practitioners. Physician consultations are readily available when needed.

The University Medical Center also provides a walk-in clinic for faculty, staff and their families who are covered under The University of Alabama medical insurance. The clinic provides fast, cost-effective urgent care for non-emergency medical problems. Additionally, a massage chair for relaxation is located in the waiting room.

Programs

WellBama is the foundation program of the OHPW, which offers a range of programs to inspire, support and motivate employees throughout the year. These include team based challenges such as Strive for Five and Strive to Scale Back, in addition to Spring Training, Walktober and the 12 Days of Wellness. Tobacco

cessation and diabetes education programs run regularly throughout the year.

Each program contains one or more of four key components: Nourish, Move, Balance, and Live. These components help employees to identify programs that support their weight loss, fitness, stress management and specific health concerns.

All OHWP programs include access to nutritional tips, counseling and education, in addition to materials that support individual and team-based health and wellness initiatives. Full program details can be found at www.wellness.ua.edu.

Contact Details

Office of Health Promotion and Wellness
wellness.ua.edu
205-348-0077

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a free, confidential counseling service available to all employees and their family members. EAP is a University paid benefit and is designed to make counseling services as easy to access as possible. The services are provided by licensed counselors and social workers trained to help individuals who are experiencing personal, professional, or family problems.

What kind of issues does my EAP address?

Employees and their eligible family members can call EAP for assistance with any life issue that causes concern. Some common issues counselors are ready to provide assistance with include:

- Marital Concerns
- Relationship Issues
- Parenting Issues
- General Stress
- Substance Abuse
- Emotional Stress/Anger
- Job Stress
- Caregiver Burnout
- Financial Concerns
- Anxiety/Depression
- Grief/Loss
- Elder Care Issues

How does the program work?

When someone calls EAP, he/she will be scheduled for an appointment to talk with one of our counselors. It's as simple as that. In the event that their issues are beyond the scope of EAP services, we will assist with finding other agencies or professionals who can help. We will make every effort to not only find an excellent match between client and provider, but take into account insurance needs as well.

When there is a need after traditional office hours, an EAP counselor is just a phone call away. Our local and toll free numbers are answered, live, 24 hours a day. The caller will be connected to the counselor on call who will speak with them personally.

How do I contact EAP?

The services are provided through the DCH Employee Assistance Program. Should you or a member of your family need assistance, please contact:

DCH EMPLOYEE ASSISTANCE PROGRAM

201 Towncenter Blvd.

Tuscaloosa, AL 35406

Phone: 205-759-7890

Toll-free: 866-840-0750

Fax: 205-759-7893

www.dchsystem.com/eap

Office Hours:

Monday through Thursday: 8:30 a.m. until 7:00 p.m.

Friday: 8:30 a.m. until 5:00 p.m.

Voluntary Critical Illness Insurance

Critical Illness insurance plan is offered through Aflac. This coverage will pay eligible individuals a lump-sum payment if they are diagnosed with a covered critical illness such as cancer, heart attack, stroke, renal (kidney) failure. New employees have 60 days in which to elect coverage in amounts ranging from \$5,000 up to \$50,000 and \$25,000 for a spouse or sponsored adult dependent. Coverage will be effective the date the eligible employee signs the application.

Underwriting Guidelines – Guaranteed Issue

Guaranteed Issue is offered for new hires if enrolled within 60 days of hire date. The following options are available:

Guaranteed Issue - \$30,000 for employee and \$15,000 for spouse or sponsored adult dependent.

Modified Guaranteed Issue - Amount over \$30,000 for employee and amount over \$15,000 for spouse or sponsored adult dependent. All applicants are required to answer underwriting questions. These questions are knockout questions. Any “yes” response results in a declination. If participation requirements are met, employees who would otherwise be declined will be issued the lesser of the amount applied for or the Guaranteed Issue limit.

Individual Eligibility

All regular full-time employees who work at least 38.75 hours or more per week and regular part-time who work at least 20 hours or more per week are eligible to enroll.

If an employee is eligible, their spouse or sponsored adult dependent and all children and sponsored child dependents of the Insured who are less than 26 years of age are eligible for coverage.

Spouse or Sponsored Adult Dependent Coverage

The employee may elect to purchase spouse or sponsored adult dependent coverage. In order to apply for this coverage, the employee must also apply. The spouse or sponsored adult dependent amount may not exceed 50% of the employee amount, subject to the minimum face amount of \$5,000. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse or sponsored adult dependent can still obtain coverage and would then become the primary Insured. Coverage would be limited to face amounts between \$5,000 and \$25,000.

Dependent Child and Sponsored Child Dependent Coverage at No Additional Charge

Each eligible dependent child is covered at 25% of the primary insured amount at no additional charge. The payment of benefits for a dependent child does not reduce the face amount of the primary insured. Child coverage would end when benefits for the last remaining adult insureds is paid in full. Children-only coverage is not available.

Portability

When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. The employee will continue the coverage that is in-force on the date employment ends, including dependent coverage then in effect.

The employee will be allowed to continue the coverage until the earlier of the date the employee fails to pay the required premium or the date the group master policy is terminated. Coverage may not be continued if the employee fails to pay any required premium or the group master policy terminates.

Group Critical Illness Benefits

First Occurrence Benefit – After the Waiting Period, an Insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Covered Critical Illnesses **	
Illnesses Covered Under Plan	% of Face Amount
Cancer (Internal or Invasive)	100%
Heart Attack	100%
Major Organ Transplant	100%
Renal Failure (End Stage)	100%
Stroke	100%
Carcinoma in Situ+	25%
Coronary Artery Bypass Surgery+	25%

** At age 70, benefits are reduced by 50%.

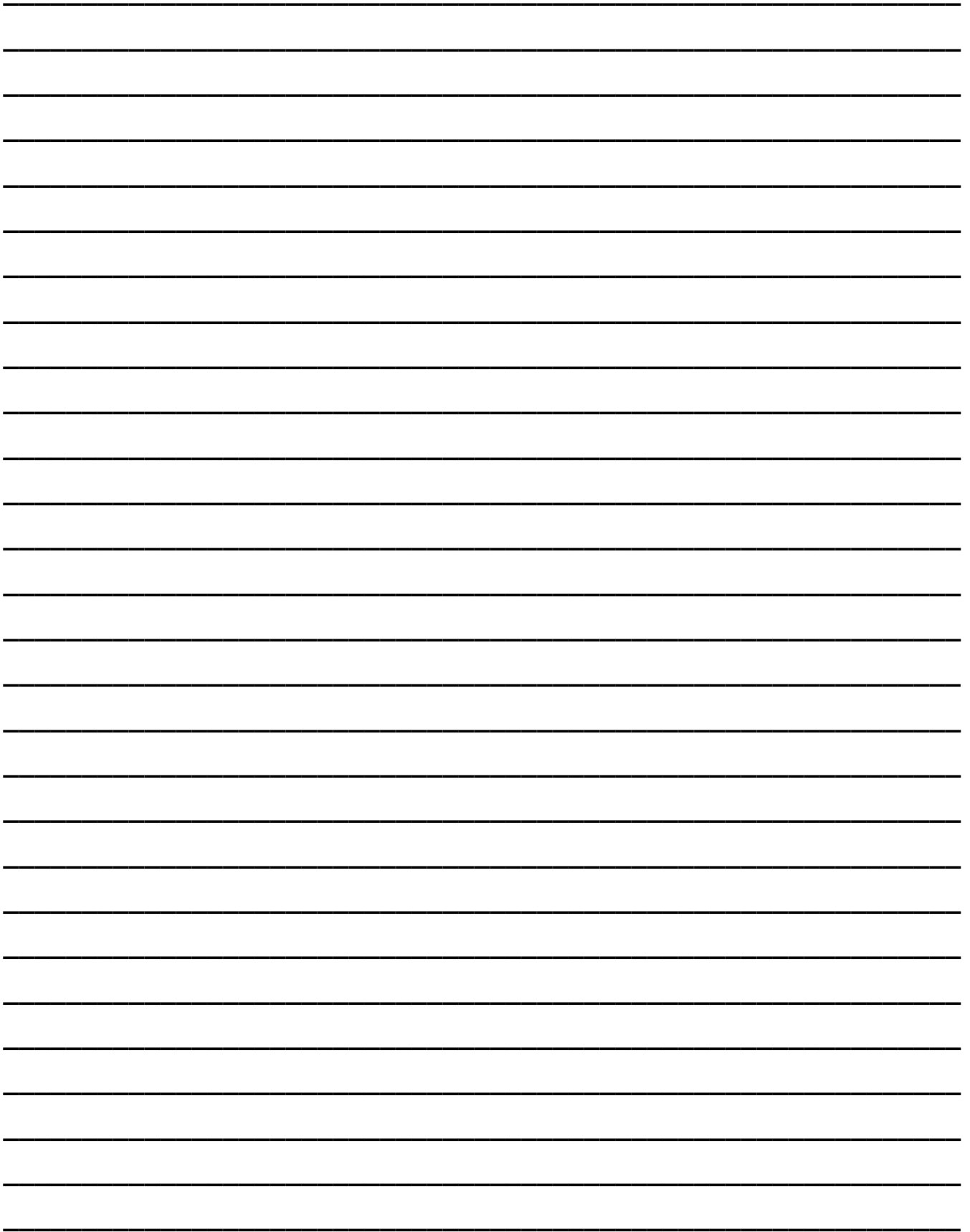
Additional Benefit Rider

Covered Critical Illnesses	
Illnesses Covered Under Plan	% of Face Amount
Alzheimer's	25%
Parkinson's	25%

Aflac will pay the indicated percentages of the applicable benefit amount for loss occurring while this Additional Benefit Rider is in force. Aflac will not pay benefits under this Rider if these conditions result from another Critical Illness. The dates of loss for more than one Specified Critical Illness must be separated by at least 12 months for Aflac to pay benefits for multiple Specified Critical Illnesses. Aflac will pay benefits under this Rider only once. When the benefit is paid, coverage under this Rider for that individual terminates.

How to Enroll

For more information about the plan details, limitations and exclusions, rates and how to enroll, go to www.aflac.com/ua.



Forms



Benefit Enrollment & Change Form 2012 Plan Year

Please complete this form if you are a new enrollee or changing coverage.

Indicate date of hire (mm/dd/yy) / / Type of qualifying event (marriage, birth, adoption, death of spouse, etc.) _____ Indicate date event occurred / / Indicate dental effective date / /	New Enrollee/Cancel <input type="checkbox"/> New enrollment <input type="checkbox"/> Cancel Medical <input type="checkbox"/> Cancel Dental <input type="checkbox"/> Cancel Vision	Reason for Change <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Add spouse/child/sponsored adult or child dependent <input type="checkbox"/> Remove spouse/child/sponsored adult or child dependent <input type="checkbox"/> Other (indicate reason) _____
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Employee Last Name	First Name	MI	Social Security Number	Birthdate (mm/dd/yy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address			City	State	Zip Code
Email Address			Office Phone (include area code)	Home Phone (include area code)	

Note: If you choose to enroll in any of the following benefit options, your contributions will be deducted from your paycheck on a pre-tax basis. You cannot change your benefit elections during the year except within 30 days after a qualifying event occurs (e.g., marriage, divorce, birth, etc.).

Group 79912 -	Declination	Employee		Family	
Medical – Blue Cross Blue Shield (Div ____)		Biweekly Rate	Monthly Rate	Biweekly Rate	Monthly Rate
Annual Salary \$26,000 or less	<input type="checkbox"/> I decline medical	<input type="checkbox"/> \$22.15	<input type="checkbox"/> \$48.00	<input type="checkbox"/> \$114.46	<input type="checkbox"/> \$248.00
Annual Salary > \$26,000	<input type="checkbox"/> I decline medical	<input type="checkbox"/> \$29.54	<input type="checkbox"/> \$64.00	<input type="checkbox"/> \$133.85	<input type="checkbox"/> \$290.00
Select effective date of medical coverage: <input type="checkbox"/> Date of Hire <input type="checkbox"/> First of month following DOH	Do you or your dependents have other medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Family member: _____		Plan name: _____		Employer: _____

Effective the first day of the month following your hire date	Declination	Employee Monthly Rate	Employee +1 Monthly Rate	Family Monthly Rate
Dental – Blue Cross Blue Shield	<input type="checkbox"/> I decline dental	<input type="checkbox"/> \$21.00	<input type="checkbox"/> \$42.00	<input type="checkbox"/> \$60.00
Vision - UnitedHealthCare	<input type="checkbox"/> I decline vision	<input type="checkbox"/> \$5.41	<input type="checkbox"/> \$9.99	<input type="checkbox"/> \$17.47

List dependents & applicable information	Birthdate mm/dd/yy	Social Security Number	Gender M/F	Relation to you **	Medical Y/N	Dental Y/N	Vision Y/N
Dependent Name (Last, First, MI)							

**Relation to Employee Codes: Spouse = S, Child = C, Sponsored Adult Dependent = SDA, Sponsored Child Dependent = SDC

AUTHORIZATION - I have read and understand the benefit options available to me under The University of Alabama benefit program. I acknowledge the decisions indicated on this form and authorize the University to withhold the cost of coverage from my pay on a pre-tax basis. I understand I cannot change my coverage decision and any applicable coverage contribution except at the annual open enrollment or within 30 days following a qualifying life event or family status change. By my signature below, I also acknowledge that all of the information provided and statements made on this form are true and correct to the best of my knowledge. I authorize any health provider to furnish necessary information requested by my health plan for claim payment, for the quality assurance/peer review program or for compliance with state and federal law. I will abide by my plan's coordination of benefits and subrogation provisions. I have read the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Women's Health and Cancer Rights Act Notice and Flex Spending Accounts benefits guide and procedures on the reverse of this form.

Signature: _____ Printed Name: _____ Date: _____

Please consult your summary plan descriptions for a full explanation of benefits.

Important Disclosure Notice:

Notice of Group Health Plan Special Enrollment Rights:

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

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

To request special enrollment or obtain more information, contact your employer at the telephone number or address listed for your employer in this enrollment application.

Notice of Group Health Plan Pre-existing Conditions Exclusion:

This group health plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before enrolling in this plan, you might have to wait a certain period of time before this plan will provide coverage for that condition. This exclusion applies only to conditions which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this pre-existing condition exclusion period by the number of days of your prior "creditable coverage" so long as you have not had a break in coverage of at least 63 days. Most prior health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, U.S. Military, TRICARE, State Children's Health Insurance Program (SCHIP), Federal Employee Program, Peace Corps Service, state high risk pool, or a public health plan, established or maintained by a State, U.S. Government, foreign country or any political subdivision of a State, U.S. Government of foreign country. You may request a certificate of creditable coverage from a prior plan or issuer. There are also other ways that you can show you have creditable coverage.

To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should attach a copy of any certificates of creditable coverage or other documentation you have to this enrollment application. If you do not have a certificate of creditable coverage, but you do not have prior health coverage, Blue Cross and Blue Shield of Alabama will help you obtain one from your prior plan or issuer, if necessary.

All questions about pre-existing condition exclusions and creditable coverage should be directed to your employer at the telephone number and address listed for your employer in this enrollment application.

Even if you have no pre-existing conditions, benefits may not be available under other provisions of the plan. For example, the services may be excluded or may require preapproval. Be sure to read your Summary Plan Description for details.

Women's Health and Cancer Rights Act Notice:

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

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

Flexible Spending Account (FSA) Election Form (2012 Plan Year)

I. Please provide the following information:

Employee Last Name	First Name	MI	Social Security Number	Office Phone
Street Address	City	State	Zip Code	Email Address

II. Plan Elections *(must be in whole dollars)*

New Enrollee Declination

I decline to enroll in the: Healthcare Flexible Spending Account Dependent Care Flexible Spending Account Date: _____

Change Flexible Spending Account Deductions

Due to a qualifying life event or family status change, I wish to: Cancel Change - the following accounts:

- Healthcare Flexible Spending Account
 Dependent Care Flexible Spending Account

NOTE: Please indicate the type of qualifying life event or family status change (marriage, birth, adoption, death of spouse, etc.):

Date qualifying life event or family status change occurred: _____

Healthcare Flexible Spending Account (HFSA)

For Plan Year: January 1, 2012 to December 31, 2012

(Out-of-Pocket Healthcare Expenses)

I wish to enroll in the Healthcare Flexible Spending Account and elect to have \$_____ deducted annually (total amount for 2012) from my salary before taxes to reimburse me for eligible healthcare expenses that I incur during the plan year specified above

Minimum annual amount that can be elected is \$125 Maximum annual amount that can be elected is \$8,000

Dependent Care Flexible Spending Account (DCFSA)

For Plan Year: January 1, 2012 to December 31, 2012

(Childcare expenses for a dependent child under age 13, or care of an incapacitated dependent or spouse)

I wish to enroll in the Dependent Care Flexible Spending Account and elect to have \$_____ deducted annually (total amount for 2012) from my salary before taxes to reimburse me for eligible dependent care expenses that I incur during the year specified above. Reimbursement from this and other dependent care plans for which I may be eligible is limited to \$5,000 per year, or \$2,500 per year if I am married filing separately. Reimbursement is further limited to my earned income or my spouse's earned income, whichever is less.

Minimum annual amount that can be elected is \$125 Maximum annual amount that can be elected is \$5,000

III. Certification - I understand that:

- My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.
- I cannot change this election during the plan year unless I have a qualifying life event or family status change and then change the election within 30 days of the qualifying event.
- Any amounts remaining in my spending accounts for the year 2012 that have not been **incurred** by December 31, 2012 will be forfeited.
- Participants must file all claims for the 2012 plan year by March 31, 2013.
- My Social Security benefits may be reduced by this election.
- Account balances are updated after claims are processed.
- This election replaces any previous elections and will terminate on the earliest of:
 - (1) the end of the plan year;
 - (2) when I am no longer an employee eligible to participate in the plan;
 - (3) plan termination.

Signature _____ Date: _____

Printed Name: _____

Return Form To:
 HR Service Center
 Rose Administration
 Room G-69, Box 870174
 205-348-7732

Please read Instructions on next page before completing this form. Do not erase or attempt to make corrections; use a new form.

Name of Employer: **University of Alabama**_____

Group Policy No. **9118866**_____ Insured's Social Security No. _____

In accordance with the conditions of the Group Policy listed above, I hereby revoke any previous designations of primary beneficiary (ies) and contingent Beneficiary (ies) (if any) and designate as primary beneficiary (ies) and contingent beneficiary (ies) (if any) in the event of the insured's death, the following:

Primary Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

In the event said primary beneficiary (ies) predecease(s) the insured, I designate as contingent beneficiary (ies)

Contingent Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

If no beneficiary or contingent beneficiary designated shall be living following the insured's death, the amount payable by reason of the insured's Death shall be payable as provided in the Group Policy.

Note: See Next Page for Important Information

Trust (ee) Designation (applies only if a trust has been created in an executed trust agreement)

Name of Trustee(s) _____
 Address _____ City _____ State _____ Zip Code _____
 and successor(s) in trust, as Trustee(s) under _____
(*Title of Agreement*)

Dated _____ executed by me and said Trustee(s).

MetLife shall not be responsible for the application or disposition of the proceeds by said Trustee(s), and the receipt of the proceeds by said Trustee(s) shall be full discharge of the liability of MetLife under the Group Policy.

If this form is executed by the insured, it is understood and agreed, however, that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, and payment to the estate's legal representative based on such proof shall be full discharge of liability of MetLife under the Group Policy or certificate.

If this form is executed by the current owner (who is not the insured), it is understood and agreed, however, that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the current owner, if living at the insured's death, or the current owner's estate if the current owner is not living at the insured's death, and payment to the estate's legal representative based on such proof shall be full discharge of liability of MetLife under the Group Policy or certificate.

Trust(ee) (Under Will) Designation (applies only if a trust has been set forth in your Will)

The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

If for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, I hereby designate **My Estate** as beneficiary and any payment made in good faith to the legal representative of my estate shall be full discharge of the liability of MetLife under the Group Policy.

I reserve the right to change the designated beneficiary(ies) at any time without (his/her/their) consent.

(Please Print)

 Name of Insured or Owner (if assigned) _____ Daytime Phone No. _____

 Street Address _____ City _____ State _____ Zip Code _____

 Signature of Insured or Owner (if assigned) _____ Date Signed _____

Submit Completed Form To MetLife Recordkeeping Center and Retain a Copy for Your Records

GENERAL BENEFICIARY INFORMATION

You may find the following definitions helpful in completing your Beneficiary Designation form.

Primary Beneficiary: Your primary beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds. You may have the proceeds divided among several primary beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Contingent Beneficiary: Your contingent beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds if your primary beneficiary(ies) (see definition above) predecease(s) the insured. You may have the proceeds divided among several contingent beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Trust(ee) Designation: If you plan to have the insurance proceeds distributed through a Trust, you should complete this section with the appropriate information. Your Trust(ee) will be held fully responsible for the application for and disposition of the insurance proceeds.

This section should only be used if you have a legally drawn inter vivos trust agreement or an appropriate Trust(ee) is designated under your Last Will and Testament. If you complete this section, do NOT complete the Primary or Contingent Beneficiary sections.

An inter vivos trust is a trust established during the life of the trustor (the person who creates the trust) for the benefit of the trustor or other living persons.

INSTRUCTIONS FOR COMPLETING BENEFICIARY DESIGNATION

1. Fill in the insured's Name of Employer, Group Policy Number (found on your certificate) and Social Security Number at the top of the form. At the bottom of the form, fill in the name of the insured person or owner (if assigned), the daytime phone number, address, and sign and date the form.
2. Fill in the Primary Beneficiary(ies) and Contingent Beneficiary(ies), if any. For each Primary and Contingent Beneficiary listed, enter the relationship (when the relationship of the beneficiary is other than by blood or marriage, the relationship should be shown as "Nonrelative"), date of birth, address(es) (permanent residence) and percentage of share (all shares must add up to 100%).
3. If you wish to name a Trust(ee) as beneficiary, complete one of the two Trust(ee) Designations **instead** of the Primary and Contingent Beneficiary sections. If the trust is an inter vivos trust, check only the first Trust(ee) Designation box, and complete the top Trust(ee) designation. You should enter (1) the name and address of the Trust(ee); (2) the Title of the Agreement; and (3) the date of its execution. **NOTE: AN INTER VIVOS TRUST MUST BE A LEGALLY DRAWN AGREEMENT.**

If you wish to make a Trust(ee) under Will Designation, check only the second Trust(ee) Designation box. **NOTE: A TRUST(EE) UNDER WILL (OR TESTAMENTARY TRUST(EE) MUST BE ESTABLISHED UNDER THE LEGALLY DRAWN LAST WILL AND TESTAMENT OF THE INSURED OR OWNER (IF ASSIGNED).**

4. The owner of the coverage should sign and date the form in the spaces provided. Make a copy for your records.

Send the completed form to the **MetLife Recordkeeping Center, P.O. Box 6169, Utica, NY 13504-6169.**

If you wish to name more beneficiaries than this form provides for, secure an additional copy. Complete your list of beneficiaries on that form. Attach the additional form to the first, indicating clearly on **each** form the number of additional forms attached. For example, if three forms are used, number the forms as follows: 1 of 3, 2 of 3 and 3 of 3.

It is important that you review your beneficiary designation periodically to ensure that the beneficiary information you supplied is up to date.

You may change or revoke your beneficiary designation at any time by completing a new Beneficiary Designation form.

PLEASE NOTE

If death occurs and a minor (a person not of legal age) or your estate is the beneficiary, it will be necessary to have a guardian or an administrator appointed before any death benefit can be paid. This means court expenses for the beneficiary and delay in the payment of the insurance proceeds. Please take this into consideration when naming your beneficiary.

ENROLLMENT FORM MEMBER INFORMATION RECORD

Teachers' Retirement System of Alabama
P. O. Box 302150 • Montgomery, Alabama 36130-2150
(334) 832-4140 or 1-800-214-2158
Web site: www.rsa.state.al.us

FOR TEACHERS' RETIREMENT SYSTEM USE ONLY
Comments: _____

Check One:

- New Member**
- Transfer from another TRS Agency**

Please Print; No Initials

Name: _____
Last First Middle Given Maiden

Social Security Number: _____ - - **Sex:** Male Female **Status:** Married Single Widowed Divorced

Date of Birth: ____ / ____ / ____

Address: _____
Street or P. O. Box City State Zip

Name of Spouse: _____ **Spouse's Date of Birth:** ____ / ____ / ____
Last First Middle Given

Position You Will Hold:

- 1 Teacher 3 Superintendent 5 Clerical 7 Maintenance 9 Mechanic
- 2 Principal 4 Administrative 6 Lunchroom 8 Bus Driver 10 Other: Specify _____

Have you ever worked for a state agency other than in public education? Yes No

Have you ever been a member of the Teachers' Retirement System? Yes No

Were you a member before you started this job? Yes No **Have you ever withdrawn an account?** Yes No

If the answer to any of the previous three (3) questions is yes, please complete the applicable columns listing the most recent employment first.

Employing Agency	City	Year	Under What Name	Date Terminated

I certify that I am not presently a member of any other state supported retirement plan in Alabama and have completed to the best of my knowledge and belief all statements and answers printed herein.

Signature of Member: _____ **Date:** _____

TO BE COMPLETED BY EMPLOYING AGENCY

Employing Agency: _____ **Date of Employment:** _____

Annual Contract Salary: _____ **Number of Days Contracted:** _____

Employer Signature: _____ **%of Full Time:** _____

Title: _____ **Date Submitted:** _____

Please type or print giving complete information.

DESIGNATION OF PRIMARY BENEFICIARY(IES) _____

I, the undersigned, do hereby designate the following individuals as my primary beneficiary(ies) to whom I instruct the Board of Control of the Teachers' Retirement System of Alabama to pay, in the event of my death before retirement on pension, any preretirement death benefit and/or group term life insurance payments due upon my death:

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____
Street or P. O. Box City State Zip Code

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____
Street or P. O. Box City State Zip Code

DESIGNATION OF CONTINGENT BENEFICIARY(IES) _____

In the event the primary beneficiary(ies) designated above does **not** survive me, I hereby authorize the Teachers' Retirement System of Alabama to pay the benefits to the beneficiary(ies) named below:

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____
Street or P. O. Box City State Zip Code

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____
Street or P. O. Box City State Zip Code

I agree on behalf of myself, my heirs and assigns that payment so made shall be a complete discharge of the claim and shall constitute a release of the System from any further obligation on account of the benefit. I hereby direct that should I survive either or both of the before mentioned beneficiaries, the amount which otherwise would have been payable to the beneficiary had he/she been living shall be paid to my estate or to such other beneficiary as I shall hereafter nominate by written designation filed with the Teachers' Retirement System of Alabama in accordance with the rules and regulations prescribed by the Board of Control.

Signature of Applicant: _____ **Date:** _____

Please have your signature acknowledged before a Notary Public .

STATE OF ALABAMA, COUNTY OF _____

On this ____ day of _____, 20 __, personally appeared before me the said named _____ to me known and known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged that he/she executed the same and being duly sworn by me, made oath that the statements in the application are true.

Signature of Notary Public: _____

(Seal)

My Commission Expires: _____

DESIGNATION OF BENEFICIARY PRIOR TO RETIREMENT

In the event that you should die prior to your retirement, your benefit would be disbursed in one of the following ways:

- If you are *any age with 25 or more years of service or over 60 with 10 or more years of service*, your benefit payable is a choice of:
 1. Option 3 monthly benefit (50% allowance) to designated beneficiary.
 2. Return of member contributions and total earned interest plus death benefit equal to the salary on which the member made retirement contributions for the previous scholastic year (July 1 – June 30).*
- If you are *under 60 between 1 and 25 years of service or over 60 between 1 and 10 years of service*, your benefit payable is the return of member contributions and total earned interest plus death benefit equal to the salary on which the member made retirement contributions for the previous scholastic year (July 1 – June 30).*
- If you are *any age with less than 1 year of service and the death was job-related*, your benefit payable is the return of member contributions and total earned interest plus death benefit equal to annual earnable compensation of member at the time death occurs.*
- If you are *any age with less than 1 year of service and the death was not job-related*, your benefit payable is the return of member contributions and total earned interest plus matching death benefit which is limited to a \$5,000 maximum.

Note: If no individual has been designated as beneficiary, the appropriate lump sum payment will be made to the estate.

* If the death occurred more than 180 calendar days after the member's last day in pay status, or if the deceased had applied for a refund of contributions, or terminated employment, the lump sum payment would be the same as shown in the last example.

FLEXIBLE SPENDING ACCOUNT

Reimbursement Request Form

Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits Statement* (if applicable) from your insurance carrier, or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each health care claim. For dependent care reimbursement you have two choices: (1) Fill out all items in the **Dependent Care Expenses** section and attach a receipt of your payment, **OR** (2) Fill in your dependent's name, age, date of service and the requested amount, and have your Day Care provider fill out the **Affidavit of Dependent Care Provider**. You must sign and date this form and attach any corresponding receipts in order for us to process this claim. You have permission to photocopy this form.

PERSONAL INFORMATION	
Employer's Name	Email Address
Employee's Name	Date of Request
Employee's Social Security Number	Daytime Phone Number

HEALTH CARE EXPENSES					
Patient Name	Relationship	Age	Date of Service	Type of Service (Medical, Dental, etc.)	Requested Amount
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
Total:					

DEPENDENT CARE EXPENSES			
Dependent's Name	Age	Date of Service	Requested Amount
		From To	
1.			
2.			
3.			
Total:			

AFFIDAVIT OF DEPENDENT CARE PROVIDER		
I have provided adult/child care for _____, age _____, for the period beginning _____ And ending _____. Services were provided by _____ for a fee of \$ _____.		
_____ Signature of Provider	_____ Tax ID# or SS	_____ Date

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Flexible Spending Account, nor are reimbursable from any other source. I hereby authorize Flexible Corporate Plans, Inc. to obtain necessary information from all physicians, hospitals, daycare providers, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

Employee Signature

Date

Flexible Corporate Plans, Inc.

P.O. Box 381717, Birmingham, AL 35238 ♦ (205) 995-1222 ♦ Toll Free: 1-888-505-4557 ♦ Fax: (866) 238-8224

EDUCATIONAL BENEFIT FORM

INSTRUCTIONS:

Rev. 1/1/2012

- 1) An application must be completed each **academic year** for employees/retirees applying for the benefit. One application covers Fall, Spring, and Summer terms.
- 2) Complete sections I, II, and III for employee and/or dependents applying for the benefit.
- 3) Section IV should be **completed** and **signed** by the employee's college or departmental budget or fiscal representative or it will not be accepted.
- 4) Return completed application to the HR Service Center, Box 870174, at least **one month prior** to the registration payment confirmation.

TAX IMPACT: Educational benefits received by dependents and sponsored dependents of University employees are almost always taxable to the employee if the eligible dependent is enrolled in graduate school. For those educational benefits which are taxable, Federal, State, and Social Security taxes will be withheld from the employee's payroll checks received near the end of each term in which the eligible dependent was enrolled and received an educational benefit. This will usually occur in May for the spring semester, August for the summer terms, and November for the fall semester.

NOTE: It is the responsibility of the applicant to report any account number distribution changes to the HR Service Center. It is also the responsibility of the applicant to report changes that affect eligibility, e.g. termination of employment, marriage of a dependent or sponsored dependent child and when dependents or sponsored dependent children reach age 26.

THIS APPLICATION IS FOR (Check all that apply):

<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse or Sponsored Adult Dependent
<input type="checkbox"/> Child	<input type="checkbox"/> Sponsored Child Dependent

I. EMPLOYEE INFORMATION

EMPLOYEE LAST NAME	FIRST NAME	MIDDLE INITIAL	EMPLOYEE CWID or SSN	ACADEMIC YEAR APPLYING FOR
TITLE	DEPARTMENT/DIVISION		CAMPUS BOX NUMBER	CAMPUS PHONE NUMBER
EMPLOYMENT STATUS	<input type="checkbox"/> Regular full-time		<input type="checkbox"/> Regular part-time	<input type="checkbox"/> Retired

II. STUDENT INFORMATION

EMPLOYEE	LAST NAME	FIRST NAME	MI	DOB	CWID
COURSE OF STUDY (Check all that apply):					
<input type="checkbox"/> Undergraduate			<input type="checkbox"/> Graduate		
SPOUSE or SPONSORED ADULT DEPENDENT	LAST NAME	FIRST NAME	MI	DOB	CWID
CHILD/SPONSORED CHILD DEPENDENT	LAST NAME	FIRST NAME	MI	DOB	CWID
CHILD/SPONSORED CHILD DEPENDENT	LAST NAME	FIRST NAME	MI	DOB	CWID
CHILD/SPONSORED CHILD DEPENDENT	LAST NAME	FIRST NAME	MI	DOB	CWID

III. CERTIFICATION AND SIGNATURE OF EMPLOYEE/RETIREE

<i>I certify that the information provided on this form is true and complete (EMPLOYEE/RETIREE SIGN BELOW)</i>	DATE	E-MAIL ADDRESS
--	------	----------------

IV. EMPLOYEE INFORMATION (To be completed by the College or Departmental Budget or Fiscal representative.)

Write in the Banner departmental account number(s) (FOAP) to which this grant is to be charged. This should reflect the employee's permanent salary line FOAP. Dependent tuition benefits may not be charged to grant funds (2xxxx, 7xxxx) as per Office of Research. If more than one FOAP is indicated, enter the percentage to be charged and indicate Acct 605535 for employee educational benefits or 605540 for dependent educational benefits.

COA	FUND	ORGN	ACCT	PROG	%

BENEFITS/STUDENT RECEIVABLES USE ONLY
FTE: _____

APPROVED BY: _____

DATE APPROVED: _____

DATE RECEIVED: -----

 Signature of Department Budget
 or Fiscal Representative

 Date



CONTINENTAL AMERICAN
INSURANCE COMPANY

ENROLLMENT FORM

Please Mail: Post Office Box 427
Columbia, South Carolina 29202
(800) 433-3036

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
Critical Illness		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last)		S.S.N./ ID Number		Gender	Date of Birth
Street Address		City		State	Zip
Employer		Job Class	Location		Date of Hire
Hours Worked	Daytime Phone No. ()	Beneficiary Name / Relationship (estate unless designated otherwise)			
Spouse's Name (if coverage is requested)		Gender	Spouse Date of Birth		
			Employee	Spouse	
Are you actively at work?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
Are you now hospitalized or unable to perform your normal duties and activities?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you used tobacco products in the last 12 months?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	

CRITICAL ILLNESS Employee Employee & Spouse Section 125: Yes No

Employee Face Amount: \$ _____ **Employee Cost per pay period:** \$ _____

Spouse Face Amount: \$ _____ **Spouse Cost per pay period:** \$ _____

		Employee	Spouse
1	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever been treated for or diagnosed with a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

- Does this coverage replace or change any existing insurance? YES NO
- If "Yes," provide carrier and policy number: _____

CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance.

Deduction start date _____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____ Agent # _____ State of Enrollment _____

Notices

*** VERY IMPORTANT NOTICE ***
COBRA CONTINUATION OF COVERAGE

A Federal Law (Public Law 99-272, Title X, commonly known as C.O.B.R.A.) requires that most employers sponsoring group health plans offer employees and their families the opportunity for temporary extension of health coverage (called "continuation of coverage") at group rates in certain instances where coverage under the plan would otherwise end. The Health Insurance Portability and Accountability Act (HIPAA) of 1996, made changes to three areas of the C.O.B.R.A. continuation coverage rules. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the C.O.B.R.A. continuation coverage provisions. Both you and your spouse/dependents (if any) should take time to read this notice carefully.

If you are covered under our group health plan, you have the right to choose this continuation coverage if you lose your group health coverage because of reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Individuals entitled to C.O.B.R.A. continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. In order to be a qualified beneficiary, an individual must generally be covered under a group health program on the day before the event that caused a loss of coverage (such as a termination of employment, divorce from or death of a covered employee). A child who is born to the covered employee or who is placed for adoption with the covered employee, during a period of C.O.B.R.A. continuation coverage, is also a qualified beneficiary.

If you are the spouse of an employee covered by our group health plan, you have the right to choose continuation coverage under C.O.B.R.A. for yourself if you lose group health coverage under our group health plan for any of the following reasons:

- (1) The death of your spouse;
- (2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- (3) Divorce or legal separation from your spouse; or
- (4) Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by our group health plan, he or she has the right to C.O.B.R.A. continuation coverage if group health coverage under our group health plan is lost for any of the following reasons:

- (1) The death of a parent;
- (2) A termination of a parent's employment (for reasons other than misconduct) or reduction in a parent's hours of employment;
- (3) Parents divorce or legal separation;
- (4) A parent becomes entitled to Medicare; or
- (5) The dependent ceases to be a "dependent child" under the provisions of our group plan.

A child born to or placed for adoption with the covered employee during COBRA coverage is also a qualified beneficiary with all rights of any other qualified beneficiary.

Disability: Under current law, C.O.B.R.A. continuation coverage is available for 18 months for an individual entitled to C.O.B.R.A. because termination of employment or reduction of hours of employment. However, if the individual entitled to C.O.B.R.A. is disabled (as determined under Social Security Act) at the time of termination of employment or reduction in hours, the C.O.B.R.A. coverage period may be extended to 29 months. The disability extension will also apply if the individual becomes disabled at any time during the first 60 days of C.O.B.R.A. continuation coverage. The law also provides that non-disabled family members who are qualified beneficiaries (as previously defined) entitled to C.O.B.R.A. are also entitled to the 29 months disability extension.

Under the law, you (the employee or your spouse/dependent) **have the responsibility to inform the employer** of a divorce, legal separation, or a child losing dependent status under the group health plan within 30 days of the event.

When we are notified by you that a qualifying event has happened, we will provide you with information regarding your right to choose continuation coverage. Under current law, you have at least 60 days from the date you would lose coverage to elect continuation coverage. If you do not choose continuation coverage within 60 days, your health coverage will end. If you choose continuation coverage within 60 days, your C.O.B.R.A. will become effective and you will owe premiums from the date you otherwise would have lost coverage.

If you choose continuation coverage, we are required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the program to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost health coverage because of a termination of employment or reduction in hours. In this case, the coverage period is 18 months. This 18 months period may be extended if other events (for example – divorce, legal separation, or death) occur during that 18 months period. In no event will coverage last beyond 36 months from the date of the event that originally made you eligible to elect coverage.

The law also provides that your continuation coverage may be cut short for any of the following reasons:

- (1) We no longer provide group health coverage to any of our employees.
- (2) The premium for your continuation coverage is not paid on time (within the applicable grace period).
- (3) After electing C.O.B.R.A. you become covered under another health plan that does not contain any pre-existing condition limitations or exclusions that is not satisfied by the Health Insurance Portability and Accountability Act of 1996.
- (4) After electing C.O.B.R.A. you become entitled to Medicare.
- (5) Coverage has been extended for up to 29 months due to disability and a final determination has been made that the individual is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you will have to pay all or part of the premium for your continuation coverage. There is a grace period of 30 days for the regularly scheduled premium. Once your continuation coverage terminates for any reason, it cannot be reinstated.

Please contact the HR Service Center (205) 348-7732 if you have questions about this letter or any other provision about COBRA.