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<tr>
<th>PLAN TYPE</th>
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<th>PHONE #</th>
<th>WEBSITE</th>
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<tr>
<td>MEDICAL</td>
<td>BC/BS/PEO</td>
<td>1-866-917-7537</td>
<td><a href="http://www.lhshs.com">www.lhshs.com</a></td>
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<tr>
<td>PRESCRIPTION</td>
<td>CVS CareMark</td>
<td>1-877-578-6977</td>
<td><a href="http://www.cvshealth.com">www.cvshealth.com</a></td>
</tr>
<tr>
<td>DENTAL</td>
<td>First Choice FSHP</td>
<td>1-800-574-0409</td>
<td><a href="http://www.firstchice.com">www.firstchice.com</a></td>
</tr>
<tr>
<td>LITE</td>
<td>The Hartford</td>
<td>1-800-331-7234</td>
<td></td>
</tr>
<tr>
<td>BENEFITS/ELIGIBILITY &amp; GENERAL QUESTIONS</td>
<td>LUMC Benefit Department</td>
<td>1-708-216-9401</td>
<td><a href="http://www.lhs.org/portal/office/benefits%D0%B3%D1%80%D1%83%D0%BF%D0%BF%D0%BE">www.lhs.org/portal/office/benefitsгруппо</a></td>
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<td>FLEXIBLE SPENDING ACCOUNTS</td>
<td>WegWorks</td>
<td>1-877-924-3361</td>
<td><a href="http://www.wegworks.com">www.wegworks.com</a></td>
</tr>
<tr>
<td>COUNSELING &amp; SERVICES</td>
<td>Employees Assistance Group (EAP)</td>
<td>1-708-216-0129</td>
<td><a href="http://www.lhs.org/portal/office/benefits%D0%B3%D1%80%D1%83%D0%BF%D0%BF%D0%BE">www.lhs.org/portal/office/benefitsгруппо</a></td>
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<td>COBRA (Continuation Insurance Coverage)</td>
<td>LUMC Benefit Department</td>
<td>1-708-216-9401</td>
<td><a href="http://www.lhs.org/portal/office/benefits%D0%B3%D1%80%D1%83%D0%BF%D0%BF%D0%BE">www.lhs.org/portal/office/benefitsгруппо</a></td>
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<td>EXECUTIVE PLAN</td>
<td>Health Plan, Inc.</td>
<td>1-844-360-1440</td>
<td><a href="http://www.lhs.com">www.lhs.com</a></td>
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<tr>
<td>LOAN SERVICES &amp; PERSONAL LENDING</td>
<td>Credit Union</td>
<td>1-708-216-5500</td>
<td><a href="http://www.lhs.com">www.lhs.com</a></td>
</tr>
<tr>
<td>YIN YANG</td>
<td>UnitedHealthCare</td>
<td>1-888-546-9000</td>
<td><a href="http://www.myhealthcare.net">www.myhealthcare.net</a></td>
</tr>
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<td>TUITION BENEFIT</td>
<td>Human Resources</td>
<td>1-708-216-9401</td>
<td><a href="http://www.lhs.org/portal/office/benefits%D0%B3%D1%80%D1%83%D0%BF%D0%BF%D0%BE">www.lhs.org/portal/office/benefitsгруппо</a></td>
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<tr>
<td>CONSULTATION &amp; REFERRAL SERVICE</td>
<td>Workplace Solutions</td>
<td>1-866-888-1885</td>
<td><a href="http://www.workplace.com">www.workplace.com</a></td>
</tr>
<tr>
<td>RETIREMENT</td>
<td>TransAmerica</td>
<td>1-800-394-5240</td>
<td><a href="https://retirementprogram.transamerica.com">https://retirementprogram.transamerica.com</a></td>
</tr>
<tr>
<td></td>
<td>Trinity Health Retirement Plan Office</td>
<td>1-800-701-4733</td>
<td></td>
</tr>
<tr>
<td>VOLUNTARY BENEFITS</td>
<td>The Fanning Company</td>
<td>1-866-253-9529</td>
<td></td>
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<tr>
<td>FLEXIBLE SAVING ACCOUNT</td>
<td>HealthEquity</td>
<td>1-866-272-6721</td>
<td><a href="http://www.healthequity.com">www.healthequity.com</a></td>
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<tr>
<td>AAA</td>
<td>AAA</td>
<td>1-800-241-3436</td>
<td><a href="http://www.aaa.com">www.aaa.com</a></td>
</tr>
<tr>
<td>Live Your Whole Life Wellness Program</td>
<td>1-855-481-0701</td>
<td><a href="http://www.benefitsof%C3%A1nhhealth.org/pwl">www.benefitsofánhhealth.org/pwl</a></td>
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Loyola University Medical Center and Gottlieb Memorial Hospital (GMH) are part of CHE Trinity Health, the benefits you receive are consistent with those received by colleagues of Trinity Health nationwide. Being a part of this large system means that Loyola and Gottlieb colleagues have a more robust benefit package and for most colleagues, reduced cost.

Loyola and Gottlieb Memorial Hospital have the same philosophy on salaries and benefits: They must be market-competitive, they must meet the needs of a diverse workforce, and that the organization shares its investment with colleagues. Please take a moment to review this book so that you can best use your benefits to stay healthy and well in the year ahead.

Loyola’s and Gottlieb Memorial Hospital benefits program give you more options and provides greater value from the dollars spent on benefits.

Loyola and Gottlieb Memorial Hospital pay the majority of the total cost of the health and dental insurance for all colleagues and 100% of the basic life insurance, short-term disability and long-term disability premiums.

Take this opportunity to review your benefits to make sure that the combination of plans you select accurately reflects who you are, what you value and what will meet the needs of you and your family.

Note: This document summarizes changes to Loyola University Medical Center and Gottlieb Memorial Hospital Trinity Healthcare colleague benefit plans and administration, effective January 1, 2017, for eligible colleagues. It does not have all the details of the benefit plans. These details are provided in the official plan documents, Summary Plan Descriptions, and contracts with the benefits administrators. You may visit http://mybenefits.trinity-health.org/ for copies of these documents. If any descriptions in this document conflict with information in the official plan documents or insurance certificates, the descriptions in the official plan document will prevail. Receipt of these materials is not a contract of employment. LUMC, GMH, and Trinity Health reserve the right to change benefit plans at anytime.
What You Need To Do

Overview of the Enrollment Process

1) Review your enrollment materials

This enrollment packet includes most of the information you need to complete your enrollment for 2017.

Summary Plan Descriptions and other benefits information is available at http://mybenefits.trinity-health.org/.

2) Make your choices

We encourage you to review all of your options to make sure you have the best combination of benefits for you and your family.

Here are some questions you will want to consider:

• Do you currently have adequate medical and dental coverage?
• Do you have enough life insurance for yourself and your family?
• Are any of the lifestyle benefits (e.g. Group Legal) of value to you? If these are services you need, these plans can help you save money.
• Have you considered a Pre-tax Dependent Care Account to save on childcare expenses?

3) Making Changes

You will not have an opportunity to make changes until next open enrollment or unless you experience a qualifying life status event.
When Are Benefits Effective?

House Staff members are covered for health care, dental care, vision and life insurance on the first day of employment. You must apply for coverage, complete the necessary enrollment forms and agree to payroll deductions within 30 days of eligibility (the Initial enrollment period.)

Generally, you will receive information concerning your benefit options during a new colleague orientation meeting. These meetings are held weekly. Benefit election forms should be returned within one week (however you may use the initial enrollment period to make changes).

If you do not elect the health, dental and vision benefits coverage during your initial enrollment period, you will have to wait until the next annual open enrollment. Open enrollment periods generally occur each fall for coverage beginning the following January, unless you have a qualifying life status change.

Who Can Be Covered Under The Health, Dental And Vision Plan?

When you select a Plan, you will be asked to choose among four coverage types:

- Single covers you only.
- Colleague plus Child/Children covers you and your eligible dependent children (birth certificate required).
- Colleague plus Spouse covers you and your spouse (marriage license required).
- Family covers you, your spouse and each of your eligible children.

a) Colleague Plus One Adult, benefits-eligible colleagues may cover their spouse or a non-blood-relative eligible adult living in their household with whom the colleague has a financial interdependence.

b) Colleague Plus One Adult - With Family. Plus one, benefits-eligible colleagues may cover their spouse or a non-blood-relative eligible adult living in their household with whom the colleague has a financial interdependence, as well as eligible dependents.

You must choose the same benefit plan for you and your family. For example, you cannot choose one option for your family and a different one for you. However, you can choose a different coverage level for each plan. For example you can choose single health and family dental.

Each of the following individuals is considered an eligible dependent under the Loyola/Gottlieb Memorial Hospital Benefit Plans:

- Your Spouse
- Plus One Adult
- Your children up to age 26.
- Your Plus One Adult dependent children up to age 26.

Coverage will end on the last day of the year in which the child reaches age 26. It is the colleague's responsibility to notify the Benefits Department when the dependent child attains age 26.

- Your unmarried children who you provide over half their support and have been enrolled in a credible plan prior to their 26th birthday because of a legally deemed, mental, or physical disability.
- Children who are in your custody under an interim court order prior to finalization of adoption, but not foster children.

* It is the responsibility of the colleague to notify Human Resources of a change in eligibility for the colleague or any covered dependent. Failure to provide notification within 30 days of the change in eligibility may result in the colleague assuming financial responsibility for premiums and claims paid on behalf of the colleague and also may result in disciplinary action.

Newborn children will be covered from 30-days from birth. Contact your benefits representative to complete the required form within 30 days of the birth, or adoption. A birth certificate is required. Coverage will be canceled if supporting documentation is not received.

Your health, dental and vision benefits do not cover grandchildren, siblings or parents.
For Your Benefit

Eligibility

Can I Change My Coverage?
You may change coverage only during the annual open enrollment period, unless you have a loss of coverage or a qualifying event. Qualifying events include the following:

- Change in legal marital status-including marriage, divorce, legal separation, annulment or death of a spouse,
- Change in number of dependents including birth, adoption, placement for adoption or death of a dependent.
- Change in employment status-including the colleague’s spouse or dependent’s termination or commencement of employment.
- Change in work schedule resulting in coverage loss including the colleague’s, spouse’s or dependent’s reduction in hours of employment and switching between part-time and full-time work, commencement or return from an unpaid leave of absence.
- Change in dependent status-including the dependent’s “aging-out” of the plan’s eligibility terms.
- Gain or loss of Medicare or Medicaid entitlement.
- Qualified Medical Child Support Order (QMED)

These changes must be made within 30 days of the qualifying event. Proper documentation is required (birth certificate, marriage certificate or loss/gain of coverage from another employer).

Pre-Tax Premiums for Health, Dental and Vision
Payroll deductions are made on a pre-tax basis and commence with the pay period of coverage. This pre-tax plan actually reduces your federal, state and FICA taxes and helps to offset the cost of your health, dental and vision coverage.

When Does Coverage End?
Benefit coverage may end for a variety of reasons. The most common reason is termination of employment. Coverage will also end if Loyola/Gottlieb terminates the benefit plan. While Loyola/Gottlieb does not anticipate such action, it reserves the right to terminate any benefit plan at its sole discretion.

Health, dental and vision healthcare and dependent care flex spending account coverage for House Staff members who have terminated employment continues through the end of the month in which the termination occurs.

Dependent coverage terminates either when your coverage terminates or when the individual ceases to be your eligible dependent (for example, the end of the year when your child turns 26).

Most terminated colleagues and eligible dependents have certain rights to continue benefit coverage under the Loyola/Gottlieb plans. (COBRA and conversion opportunities) The options will be explained to you at the time of termination.
Staying Healthy

Medical Plans

Medical Coverage
CHE Trinity Health is offering you three medical plan choices for 2017 which supports our efforts to provide a common experience for all colleagues and provide meaningful choices. All three plans are administered by BlueCross BlueShield and support our new clinically-integrated network structure.

The three medical plan options are the Traditional PPO, the Health Savings PPO, and the Essential PPO. Each plan offers these three tiers so you can pay less by receiving care from network providers.

- Tier1, or the CHE Trinity Health network providers, are facilities or physicians aligned with our organization that provide you with the most cost-effective care. For services unavailable through CHE Trinity Health network providers, select BlueCross BlueShield Providers will be available at the Tier 2 benefit level.
- Tier2 includes select BlueCross BlueShield Providers (facilities and physicians) not listed under Tier 1. Tier 2 providers can save you money, but not as much as using our Tier 1 network.
- Tier3 providers are out-of-network providers and this Tier provides the lowest level of coverage. You can use these facilities and physicians for care, but you will pay the most out of your pocket when you do.

How the medical plan works

Traditional PPO
If you elect coverage under the Traditional PPO, you pay for a portion of the medical services you receive until you meet the annual deductible. Then, coinsurance begins up to the annual out-of-pocket maximum.

Health Savings PPO
With the Health Savings PPO, you pay much less per pay period for coverage – leaving more money in your paycheck – and you have access to Account (HSA) to help pay for current and future medical expenses. Here’s how it works:

First
You pay the full cost of medical and prescription expenses until you reach the annual deductible (Note: preventive care services and certain preventive 90-day generic prescriptions do not require you to pay the deductible).

Second
Once you meet the deductible, you pay coinsurance until you reach the out-of-pocket maximum.

Third
Once you reach the out-of-pocket maximum, CHE Trinity Health pays 100% of all remaining eligible expenses during the year.

To learn more about the Health Savings PPO, see page 6 of this enrollment guide.

Essential PPO
The Essential PPO works the same as the Traditional PPO where you pay a portion of the medical services you receive until you meet the annual deductible. Then, coinsurance begins. If you elect the Essential PPO, you pay less in premium contributions than in the Traditional PPO, however, your out-of-pocket costs are higher.
## Medical Plan Highlights

For more information about your medical plan options, visit your benefits website.

<table>
<thead>
<tr>
<th>Highlights</th>
<th>Traditional PPO</th>
<th>Health Savings PPO</th>
<th>Essential PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1</td>
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<tr>
<td>funded account</td>
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<tr>
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<tr>
<td>Family</td>
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<td>Annual deductible</td>
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<td>Individual</td>
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<tr>
<td>Family</td>
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<td>Coinsurance</td>
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<td>Office visit</td>
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<td>Urgent care visit</td>
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<td>Inpatient admission</td>
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<tr>
<td>Outpatient admission</td>
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<td>Out-of-pocket maximum</td>
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<td>(90-day supply)</td>
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<td>Generic</td>
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<tr>
<td>Brand formulary</td>
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</tr>
<tr>
<td>Brand non-formulary</td>
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</table>

*The full family deductible must be met even if only one person in the family is receiving care. *Subject to deductible. **Subject to deductible and coinsurance. †Select, generic preventive drugs are covered at 100% and are not subject to the annual deductible. See toyola.wired or My Benefits for the complete list of eligible drugs.

Please note: You may receive two charges on your combined patient bill for services. One charge represents the facility or hospital charge and one charge represents the professional or physician fee.
How the Health Savings Account (HSA) works

When you enroll in the Health Savings PPO plan, you automatically have a Health Savings Account (HSA) through Health Equity to help you pay for current or future health care costs. CHE Trinity Health will make a full contribution to your account in January based on the coverage level you elect. In addition, you can also contribute to this account up to IRS limits:

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>CHE Trinity Health Loyola University Medical Center/Gottlieb Contributions†</th>
<th>Your Voluntary Contributions*†</th>
<th>Total IRS Allowed HSA Contributions</th>
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<tbody>
<tr>
<td>Colleague only</td>
<td>$650 (1)</td>
<td>$2,750</td>
<td>$3,400</td>
</tr>
<tr>
<td>All other coverage levels</td>
<td>$1,300 (1)</td>
<td>$5,450</td>
<td>$6,750</td>
</tr>
</tbody>
</table>

*If you are 55 or older, you can contribute an additional $1,000 in catch-up contributions to your HSA.
†May be subject to state taxation.
1 Employer contribution prorated based on benefits eligibility date

Questions about the HSA

How do I get an HSA? To be eligible for the HSA, you must enroll in the Health Savings PPO. In addition, you cannot have coverage under any other medical plan, such as Medicare, TRICARE, or coverage through a spouse’s health plan.

Who can use funds in my HSA? You and your dependents can pay for medical, dental and vision expenses with funds in your HSA. Dependents must be claimed on your tax return.

Why would I contribute to my HSA? Contributions to the HSA are a great way to save on taxes. With the HSA, you do not pay taxes on the amount you contribute through payroll deductions, the amount you withdraw for medical expenses, and the interest you earn in the account (up to amounts set by federal law). Keep in mind that you can change the amount you contribute to your HSA at any time during the plan year.

How can I use the money in my HSA? You may use the HSA to pay for qualified medical expenses now and during retirement for you and your qualified dependents.

How do I pay for medical expenses with my HSA? When you receive eligible health care services, you can pay for those services with your HSA debit card, or through several online and smartphone app options. You’ll receive more information about your payment options if you enroll in the Health Savings PPO with the HSA.

What happens if I don’t use all the money in my HSA each year? Any money you do not use during the year is carried over, without any limits. Remember, you own the money in your HSA and it is yours to keep – even when you change jobs or retire.

Can I enroll in the Health Care Spending Account (HCSA) if I have an HSA? When you enroll in the Health Savings PPO which includes the HSA, you will not have access to the health care spending account (HCSA). However, the HSA may be seen as having more advantages over the HCSA including:

- The opportunity to carry over savings from year to year – you do not forfeit any amount in your HSA at the end of the plan year (if you are currently enrolled in the HCSA, you must utilize your account funds by March 15, 2018);
- Contributions of up to $6,750 in tax-free HSA dollars each year (the HCSA maximum is $2,550);
- Your HSA dollars are saved in a bank account that may earn interest.

We encourage you to consult with a tax advisor for IRS rules and tax implications related to an HSA.

The information in this document is based on BCBSM’s current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This document is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM’s approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits At-A-Glance and any applicable plan document, the plan document will control.
Staying Healthy

Medical Plans

**Non-Surgical Weight Loss Therapy**

Along with the existing benefits for bariatric surgery, the plan will cover additional services for non-surgical weight loss treatment.

Benefits are payable 100% up to an annual benefit maximum of $500 and include:

- Outpatient counseling or therapy,
- Office visits rendered by a licensed physician for the treatment of weight loss
- Lab services performed during a course of treatment, and
- Services for weight loss rendered by a Trinity Health Ministry Organization or national recognized programs such as Jenny Craig, Weight Watchers and LA Weight Loss.

**Weight-loss expenses that are not covered are:**

- Services administered exclusively through an Internet-based forum,
- Medication or injection expenses for weight loss, unless otherwise covered for an unrelated medical condition
- Charges for food or nutritional supplements, unless included in the initial program fee,
- Charges for over-the-counter diet aids,
- Health clubs or exercise equipment,
- Services or programs that are not approved in the United States, and
- Charges in connection with acupuncture, hypnotism or biofeedback training.

**Smoking Cessation Therapy**

Covered benefits for smoking cessation treatment are payable 100% up to an annual benefit maximum of $500 and include:

- Outpatient counseling or therapy,
- Office visits rendered by a licensed physician for the treatment of smoking cessation, and
- Lab services performed during a course of treatment.

**Smoking cessation expenses that are not covered are:**

- Services administered exclusively through an Internet-based forum,
- Medication or injection expenses for smoking cessation, unless otherwise covered for an unrelated medical condition,
- Charges for over-the-counter smoking cessation aids,
- Services or programs that are not approved in the United States, and
- Charges in connection with acupuncture, hypnotism, or biofeedback training.
Staying Healthy

Medical Plans

Selecting a Provider

Trinity Health Facilities
When you use Trinity Health facilities and satellite locations, you receive the highest benefit payment level. A listing of eligible facilities is available online at bsbsm.com.

Network Providers
Network providers have signed agreements with BCBS, which means they agree to accept our approved payment for a covered benefit as payment in full. You will only pay for the deductibles, copayments and coinsurances required by your coverage.

Ask your physician if he or she participates with the BCBS PPO network in your plan area. If you need help locating a network provider, please call the phone number to locate a BCBS network provider or visit the Web site listed on the inside front cover of this handbook.

When you go to network providers, you do not have to send a claim to us. Network providers submit claims to BCBS for you, and they are paid directly by BCBS.

Nonparticipating (Out-of-Network) Providers
Nonparticipating providers have not signed agreements with BCBS. This means they may or may not choose to accept the BCBS approved amount as payment in full for your health care services.

If your present providers do not participate with BCBS, ask if they will accept the amount we approve as payment in full for the services you need. This is called participating on a "per claim" basis and means that the providers will accept the approved amount as payment in full for the specific services. You are responsible for any deductibles, copayments, and coinsurances required by your plan along with charges for non-covered services.

Staying Healthy

Prescription Drug Benefit

CVS Caremark will provide your prescription card. With this card you will be able to fill prescriptions at the Loyola and Gottlieb Memorial Hospital pharmacies and almost any retail pharmacy. For maintenance drugs, colleagues must use the CVS Caremark mail order program, the Loyola pharmacy, or the Gottlieb pharmacy. To find out if the prescription you are taking is a maintenance drug, you can call CVS Caremark at 1-877-876-6877. House Staff members will receive a 20% discount at the Loyola/Gottlieb pharmacy. The Loyola pharmacy is located on the lower level of the hospital, south of the inpatient pharmacy. You can also receive prescriptions (up to a 90-day supply) through CVS Caremark mail order. The Loyola pharmacy staff can be contacted at x69100. The Gottlieb pharmacy staff can be contacted at 708-450-4941. Prescription coverage is based on the medical plan you select.
Staying Healthy

PPO Network Information

Introducing Clinically-Integrated Network in 2017
CHE Trinity Health is pleased to introduce our Clinically-Integrated Network (CIN) structure for our medical plan options in 2017.
A CIN joins local physicians and health care providers that have made a decision to partner with a Regional Health Ministry (RHM) to deliver services focused on high quality and cost-efficient care designed to improve the health of those we serve.
Seeking care within the CIN can help you and your physician make health care decisions that ensure that you are accessing the right care, at the right time in the right setting. In addition, by utilizing our CIN you will pay less out of pocket for the care you receive, because all of the CIN providers are in our Tier 1 network.
The Affordable Care Act is changing the way we provide care. As a result, there have been many changes designed to help increase health care quality and reduce the cost in order to make it more affordable. Our health care organization is changing in order to deliver better care at a reduced cost and with an improved, people-centered care experience.
There are a lot of changes happening on the health care landscape. We believe putting them in place will better position our organization to keep our colleagues and their families healthier, fulfill our Mission, meet our nation’s needs and improve the health of the millions of people and the hundreds of communities we serve.

How Do I Access The PPO Networks?

Any time you need to use a physician or hospital, you make the choice of which physician you want to use. Benefits are always greater if you use a network hospital and/or physician; and benefits are paid at the highest level if you use a Trinity, or Loyola/Gottlieb physician. You can call the Health Care Referral Line at the Mulcahy Outpatient Center for referral information on Loyola physicians at:

1-708-216-3896

A PPO does not require you to sign up with a particular hospital or physician. You select which hospital and doctor you will use each time you need care. To learn if a particular hospital or physician is a part of the network, call Blue Cross and Blue Shield at:

1-800-810-BLUE (2583)

Advantages Of Using A Trinity, Loyola/Gottlieb Physician Or A PPO Physician

• No claim forms
• Reduced fee schedule
• Extensive physician network

Pre-Certification Of Hospital Admissions

A hospital stay can be a serious and expensive part of your course of treatment. This plan has a special program, Pre-Certification of Services, to make sure that you are not hospitalized unnecessarily. If you are admitted to (or registered as a patient at) a hospital or a rehabilitation facility, whether for emergency treatment, elective non-emergency treatment, or maternity care in excess of 48 hours for normal deliveries or 96 hours for cesarean delivery, you or a member of your family should call BCBSM at the number listed on your ID card. The call should be made prior to the elective hospital admission. It is your responsibility to obtain pre-certification of services.

A BCBSM nurse and your admitting hospital review your Inpatient treatment plan before and during your hospitalization. The objective is to help you obtain all the information you need to make informed decisions. The BCBSM nurse:

Checks if the hospital admission and length of stay are medically necessary against generally accepted medical standards; and
Suggests alternative treatment settings, if appropriate.

You will be notified by mail of the approved length of stay. Additional days may be assigned if deemed medically necessary.

The final decision regarding treatment and hospitalization is yours. Maximum allowable plan benefits are paid as long as these steps are followed prior to any inpatient hospitalization.

If you or a covered dependent are admitted to a hospital for any reason without prior approval, contact BCBSM by telephone within two business days of the admission. The contact may be made by you, a family member, or your physician.

Wellness Benefits

If you enroll in any of the three medical plans, the plan will cover certain wellness expenses. These wellness expenses include annual routine physicals.

• All immunization for dependents are covered at 100%
• All routine mammograms are covered at 100%
• Each plan covers annual physicals and routine tests.
Staying Healthy
Healthy Loyola/Gottlieb - Wellness Initiative

INSPIRE Health... Loyola/Gottlieb Cares About Your Future

Loyola/Gottlieb continues to support and promote wellness through our health plans, wellness presentations and programs, and through partnerships with the Loyola/Gottlieb centers for fitness. To keep colleagues informed about wellness activities and programs that are happening in 2017, we will promote on Loyola wired’s calendar of events, the Loyola Spirit blog, and other marketing activities. These programs are in keeping with our commitment to support the overall health and wellness of our colleagues.

Partnering With Colleagues: Why A Focus On Wellness?

The Loyola University Medical Center/Gottlieb Memorial Hospital’s healing mission calls us to provide clinical excellence to the patients that we serve. As individuals we participate in activities to promote healing and wellness for the patients we serve. As an academic medical center of distinction, committed to colleagues, we believe that the Loyola healing mission also applies to you and your health also. We are excited to offer this approach to our medical benefits that will enhance the partnership with our colleagues and assist us in achieving our goals.

The most effective way to lower medical claim costs is to improve overall health and prevent claims from occurring. Wellness activities are focused on preventing a diagnosis from developing into a chronic condition or further health problems. In fact, companies that implement specific wellness activities for colleagues/covered dependents within a medical plan, document reduced claims over a five year period. Those savings translate into better medical benefit premiums for colleagues.
**Staying Healthy**

◇ Healthy Loyola/Gottlieb - Wellness Initiative

**Live Your Whole Life**

Staying healthy all the way around - in body, mind, and spirit - makes us happier and more productive at home and on the job. At Trinity Health, we believe that an annual Health Assessment and healthy activities are essential steps in understanding your well-being. It’s so important that we provide an incentive when you and your covered spouse or eligible adult complete these steps.

To continue complying with the requirements for wellness programs, Trinity Health made some changes to the incentives for 2017. Here’s how this year’s program will work:

- All colleagues start with the Full Incentive amounts. Note: See the box to the right to understand the new options for Full and 1-Person Incentives.
- There are two Periods where you can earn LifePoints to maintain your Full Incentive amounts
- To maintain these incentives throughout the year, you need to earn 100 LifePoints in each Period by completing the required activities.

**New Incentive Structure**

There are now separate incentive amounts for colleagues and spouses/eligible adults. If both you and your spouse/eligible adult complete the activities in each period, you will maintain the Full Incentive amounts. If only one of you completes the activities in each period, you will only maintain a 1-Person Incentive amount. (See the section “Paying for Medical Coverage” for contribution rates with Full and 1-Person Incentives.)

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**Period 1 - Earn 100 LifePoints by March 31, 2017**

**Complete your Health Assessment**

The Health Assessment is an online questionnaire about your health habits. Your answers are kept secure and confidential; summary data is used to identify areas for future well-being and prevention programs.

Note: To maintain your Full Incentive amount, the health assessment must be completed by you and your covered spouse or eligible adult in Period 1 (Oct. 1, 2016 - March 31, 2017.) If you (and your spouse/eligible adult, if applicable) do not complete your health assessment by March 31, 2017, you will not maintain the incentive of a lower per pay period cost for medical coverage as of May 1, 2017.

**Period 2 - Earn 100 LifePoints by June 30, 2017**

To continue receiving the incentive throughout the year, you and your covered spouse or eligible adult need to earn 100 LifePoints by participating in a Meaningful Choice activity that interests you within Period 2. You can choose from a variety of Meaningful Choice Activities that fit your lifestyle. Some examples include talking with a health coach, completing a stage of an online journey module, tracking well-being items such as hours of sleep or time spent volunteering.

If you (and your spouse/eligible adult, if applicable) do not earn 100 LifePoints by June 30, 2017, you will not maintain the incentive of a lower per pay period cost for medical coverage as of August 1, 2017.

**Need another chance to earn your Full Incentives?**

If you did not complete the required activities by the Period 1 deadline, you still have one more chance to regain your Full Incentive amounts. If you complete both the Period 1 and Period 2 activities by June 30, 2017, you will regain the Incentive (Full or 1-Person, depending on if your spouse/eligible adult completes the activities) starting August 1, 2017.

If you feel that you are unable to complete the Live Your Whole Life incentive activities by the deadline due to extenuating circumstances (e.g. medical hardship, military deployment), you may request an exception. For your exception request to be reviewed, the form must be completed and returned prior to the end of each Period. Exception forms can be found at www.mybenefits.trinity-health.org/lywl or by calling 1.855.491.8781.

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*Colleagues and spouses/eligible adults whose medical benefits are activated and updated in your Ministry’s HRIS as active, after January 23, 2017 will not be required to complete the incentive activities to maintain the lower premium cost for medical coverage.*
Women's Preventive Care under the Affordable Care Act

Part of the Affordable Care Act (ACA) (also known as health care reform) requires employers to cover certain women's preventive care services, including contraception, under health insurance benefits at no charge.

As a health ministry of the Catholic Church, we have engaged in extensive advocacy with the support of the Catholic Health Association, to find an acceptable resolution to this issue.

The final rules from the U.S. Health and Human Services, Treasury and the Department of Labor give an accommodation to certain religious and religiously-affiliated organizations, like CHE Trinity Health, to provide an exemption from the requirement to provide contraceptive coverage to colleagues as preventive health services.

The intent of the rules is to accommodate the moral perspectives of certain religiously-affiliated employers while also providing for the preventive health care needs of their colleagues who may not share the employers' religious beliefs.

In 2017, your medical/pharmacy benefit provider will continue to provide these benefits as mandated by the ACA.

CHE Trinity Health colleagues will be provided with access to these benefits, but they will not be paid for by CHE Trinity Health or its health plans. Contact your medical/pharmacy benefit provider for further details.

Notice of Rights:

This Act requires employers who provide medical benefit plans to colleagues to communicate coverage provisions established under the Act. Trinity Health’s plan provisions are as follows:

The Trinity Health plan will not restrict benefits if you or your eligible dependent receives benefits for a mastectomy and elective breast reconstruction in connection with the mastectomy.

Benefits will not be restricted if the breast reconstruction is performed in a manner determined in consultation with your or your eligible dependent’s physician, including:

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

Benefits for breast construction will be subject to plan coverage provisions and limitation, including annual deductible, co-pay and coinsurance provisions consistent with those established for other benefits under the plan.

If you have any questions, contact Human Resources.

Staying Healthy

*Loyola/Gottlieb Center for Health & Fitness*

The Centers offer programs throughout the year which include water aerobics, access to a Personal Trainer, and nutritional classes.

Application forms for the Loyola Center for Health and Fitness and the Gottlieb Center for Health and Fitness can be obtained at each location. During open enrollment and as a new colleague, special discounts and programs are offered.

You can enroll in this center at any time. The monthly dues are at a discounted rate for all colleagues. Some classes during the year will also be available for Loyola members at a discounted rate. For more information about the center or to sign up, contact Loyola at 1-708-327-2348 or Gottlieb at 1-708-450-5790.
Staying Healthy

Dental

All of us want a great, healthy smile when we look in the mirror. Loyola/Gottlieb’s dental options help you get there! You can choose from two dental options:

- Trinity Health Delta Dental High Plan
- Trinity Health Delta Dental Standard Plan

The Delta Dental plan

You may choose a Delta Dental Plan which provides coverage for preventative, basic, major and orthodontia services after a calendar year deductible. If you choose a dentist in the Delta network, you pay less for dental care.

Loyola/Gottlieb’s dental PPO plans are administered through Delta Dental Michigan. With this dental coverage you may select the dentist of your choice.

Dental Coverage

You have a choice between two new Delta Dental plan options: the High plan and the Standard plan. Visit www.deltadentalmi.com for providers in your area.

<table>
<thead>
<tr>
<th>Dental Plan Highlights</th>
<th>High Plan</th>
<th>Standard Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$25</td>
<td>$100</td>
</tr>
<tr>
<td>Family</td>
<td>$60</td>
<td>$100</td>
</tr>
<tr>
<td>Class I - Preventive services</td>
<td>100% covered ($0 colleague cost)</td>
<td>100% covered ($0 colleague cost)</td>
</tr>
<tr>
<td></td>
<td>100% covered (Usual and Customary rates apply)</td>
<td>100% covered (Usual and Customary rates apply)</td>
</tr>
<tr>
<td>Class II - Basic services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Class III - Major restorative services</td>
<td>40% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>40% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Class IV - Orthodontics</td>
<td>50% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>50% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Maximums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per person annual (non-orthodontics)</td>
<td>$1,750</td>
<td>$1,500</td>
</tr>
<tr>
<td>Per person lifetime (orthodontics)</td>
<td>$1,500</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

NOTES: When you receive services from a non-participating dentist, you will be responsible for the difference between what your dentist charges and the non-participating dentist fee. Fluoride treatments are covered once every 12 months to age 14. Bitewing x-rays are covered once every 12 months.

Delta Dental PPO (Point-of-Service) Summary of Dental Plan Benefits

This Summary of Dental Plan Benefits should be read in conjunction with your Dental Care Certificate. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. Delta Dental’s allowance may vary by the dentist’s network participation. PLEASE NOTE - If you choose a Nonparticipating Dentist, you will be responsible for any difference between the amount Delta Dental allows and the amount the Nonparticipating Dentist charges, in addition to any Co-payment or Deductible.

- Oral exams are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable once per calendar year for people up to age 14.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Selants are only payable once per tooth per lifetime for the acclusal surface of first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.
Staying Healthy

Dental High Plan

- Composite resin (white) restorations are optional treatment on posterior teeth.
- Inlays are Covered Services.
- Porcelain crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- People with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

Having Delta Dental coverage makes it easy for our enrollees to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – PPO Dentist - $1,750 per person total per benefit year on all services except Orthodontics. $1,500 per person total per lifetime on Orthodontic Services.

Premier Dentist or Nonparticipating Dentist - $1,250 per person total per benefit year on all services except Orthodontics. $1,500 per person total per lifetime on Orthodontic Services.

These are not separate maximums by type of dentist.

Deductible – PPO Dentist - $25 single coverage; $50 family coverage.

Premier Dentist or Nonparticipating Dentist - $50 deductible per person total per benefit year limited to a maximum deductible of $100 per family per benefit year. The deductible does not apply to Diagnostic and Preventive services, Emergency Palliative Treatment, Brush Biopsy, X-rays, and Orthodontic services.

Waiting Period – Coverage will become effective after you satisfy the waiting period as defined by your Trinity Health MO.

Eligible People – See page 4 for a complete list of those person who can be covered under your benefits.

If you and your spouse are both eligible under this contract, you may be enrolled together on one application card or separately on individual application cards. Your dependent children may only be enrolled on one subscriber’s application card. Delta Dental will not coordinate benefits if both you and your spouse are employed with Trinity Health. Unless this is a Section 125 plan, subscribers and their dependents who enroll in the dental plan are required to remain enrolled for a minimum of 12 months. If this is a Section 125 plan, an election may be revoked or changed at any time if the change is the result of a change in family status as defined under Internal Revenue Code Section 125. The contractor and subscriber share the cost of this plan.

Benefits will cease on the last day of the pay period in which employment ends.

Customer Service Toll-Free Number: 800-524-0149
www.deltadentalmi.com
Staying Healthy

Dental Standard Plan

- Composite resin (white) restorations are optional treatment on posterior teeth.
- Inlays are Covered Services.
- Porcelain crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- People with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

Having Delta Dental coverage makes it easy for our enrollees to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – PPO Dentist - $1,500 per person total per benefit year on all services.

Deductible – PPO Dentist - $50 deductible per person total per benefit year limited to a maximum deductible of $100 per family per benefit year. The deductible does not apply to Diagnostic and Preventive services, Emergency Palliative Treatment, Brush Biopsy, and X-rays.

Premier Dentist or Nonparticipating Dentist - $100 deductible per person total per benefit year limited to a maximum deductible of $150 per family per benefit year. The deductible does not apply to Diagnostic and Preventive services. Emergency Palliative Treatment, Brush Biopsy, and X-rays.

If you and your spouse are both eligible under this contract, you may be enrolled together on one application card or separately on individual application cards. Your dependent children may only be enrolled on one subscriber’s application card. Delta Dental will not coordinate benefits if both you and your spouse are employed with Trinity Health. Unless this is a Section 125 plan, subscribers and their dependents who enroll in the dental plan are required to remain enrolled for a minimum of 12 months. If this is a Section 125 plan, an election may be revoked or changed at any time if the change is the result of a change in family status as defined under Internal Revenue Code Section 125. The contractor and subscriber share the cost of this plan.

Benefits will cease on the last day of the pay period in which employment ends.

Customer Service Toll-Free Number: 800-524-0149

www.deltadentalmi.com
Vision is a voluntary benefit offered to give you comprehensive coverage for well eye care. Vision care includes regular eye examinations which allow eye care doctors to detect and treat diseases at the earliest possible opportunity. We offer two vision plans to choose from:

- UNITED HEALTHCARE VISION HIGH
- UNITED HEALTHCARE VISION STANDARD.

United Heathcare Vision has eye care networks throughout the Chicago Area.

If you choose this benefit you can go in or out of network. There is a separate benefit level out of network.

If you go out of network you must fill out an out of network claim form within twelve months of service. Claim forms are available by logging in into www.myuhcvision.com or by calling United Heathcare Vision directly at 1-800-638-3120.

<table>
<thead>
<tr>
<th>UHC Vision Plan Highlights</th>
<th>High Plan</th>
<th>Standard Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network (reimbursement schedule)</td>
<td>Out-of-network (reimbursement schedule)</td>
</tr>
<tr>
<td>Benefit frequency</td>
<td>Calendar year</td>
<td>Calendar year</td>
</tr>
<tr>
<td>Vision exam</td>
<td>Covered in full</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Pair of lenses</td>
<td>$0 copayment</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Single vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trifocal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenticular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>The preferred price is a $50 wholesale allowance at independent locations or a maximum of $150 of retail allowance at retail locations</td>
<td>Up to $45</td>
</tr>
<tr>
<td>Covered frame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-covered frame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact lenses</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>(in lieu of eyeglasses)</td>
<td>$200 allowance toward contact lenses, fitting/evaluation fees and two follow-up visits instead of glasses once every 12 months. Up to 8 boxes of contact lenses are included.</td>
<td>$175 allowance toward contact lenses, fitting/evaluation fees and two follow-up visits instead of glasses once every 12 months. Up to 6 boxes of contact lenses are included.</td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional pair of eyeglasses or contact lenses</td>
<td>20% discount</td>
<td>20% discount</td>
</tr>
<tr>
<td>Additional lens options</td>
<td>The following lens options are covered in full: standard scratch-resistant coating, standard basic and high-end progressive lenses, standard polycarbonate lenses, standard anti-reflective coating, UV, tints, photochromic, Transitions®, edge coating</td>
<td>The following lens options are covered in full: standard scratch-resistant coating, standard polycarbonate lenses.</td>
</tr>
</tbody>
</table>
UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation’s leading employers through experienced, customer-focused people and the nation’s most accessible, diversified vision care network.

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating \(^1\) and the frame, or contact lenses in lieu of eye glasses.

<table>
<thead>
<tr>
<th>Copays for in-network service</th>
<th>$ 0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>Materials</td>
<td></td>
</tr>
</tbody>
</table>

**Benefit frequency**

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Exam</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Spectacle Lenses</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Frames</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Contact Lenses in Lieu of Eye Glasses</td>
<td>Every calendar year</td>
</tr>
</tbody>
</table>

**Frame benefit**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Practice Provider</td>
<td>$150.00 retail frame allowance</td>
</tr>
<tr>
<td>Retail Chain Provider</td>
<td>$150.00 retail frame allowance</td>
</tr>
</tbody>
</table>

**Lens options**

Standard scratch-resistant coating, standard basic and high-end progressive lenses, standard polycarbonate lenses, standard anti-reflective coating, UV tints, photochromic, Transitions \(^2\), edge coating — covered in full from a network provider. (Discount varies by provider.)

**Contact lens benefit**

Covered-in-full elective contact lenses

The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full. If you choose disposable contacts, up to 8 boxes are included when obtained from a network provider.

All other elective contact lenses

A $200.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.

Necessary contact lenses \(^2\)

Covered in full after applicable copay.

**Additional materials discount**

UnitedHealthcare Vision now offers an Additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. \(^3\)

**Out-of-network reimbursements** (Copays do not apply)

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$40.00</td>
</tr>
<tr>
<td>Frames</td>
<td>$45.00</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>$40.00</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>$60.00</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>$80.00</td>
</tr>
<tr>
<td>Lenticular Lenses</td>
<td>$80.00</td>
</tr>
<tr>
<td>Elective Contacts in Lieu of Eye Glasses</td>
<td>$200.00</td>
</tr>
<tr>
<td>Necessary Contacts in Lieu of Eye Glasses</td>
<td>$210.00</td>
</tr>
</tbody>
</table>

**Laser vision benefit**

UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at Lasik Plus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.
Important to Remember:

- Benefits frequency based on a calendar year.
- Your $200.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30.00, you will have $170.00 toward the purchase of contact lenses. The allowance may be separated at some retail locations between the examining physician and the optical store.
- Medically necessary contact lenses are determined at the provider’s discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming how much of a reimbursement you can expect to receive before you purchase such contacts.

Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UnitedHealthcare Vision, Attn. Claim Dept., PO. Box 30978, Salt Lake City, UT 84130. Fax: 248.733.6060

1 On all orders processed through a company owned and contracted Lab network.
2 Necessary contact lenses are determined at the provider’s discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.
3 Once all of your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.
4 The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06 and associated COC form number VCOC.INT.06.TX.
UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation’s leading employers through experienced, customer-focused people and the nation’s most accessible, diversified vision care network.

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating ¹ and the frame, or contact lenses in lieu of eye glasses.

<table>
<thead>
<tr>
<th>Copays for in-network service</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$10.00</td>
</tr>
<tr>
<td>Materials</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit frequency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Exam</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Spectacle Lenses</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Frames</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Contact Lenses in Lieu of Eye Glasses</td>
<td>Every calendar year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frame benefit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Practice Provider</td>
<td>$150.00 retail frame allowance</td>
</tr>
<tr>
<td>Retail Chain Provider</td>
<td>$150.00 retail frame allowance</td>
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<table>
<thead>
<tr>
<th>Lens options</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard scratch-resistant coating, standard polycarbonate lenses -- covered in full from a network provider. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact lens benefit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered-in-full elective contact lenses</td>
<td></td>
</tr>
<tr>
<td>The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full. If you choose disposable contacts, up to 6 boxes are included when obtained from a network provider.</td>
<td></td>
</tr>
<tr>
<td>All other elective contact lenses</td>
<td></td>
</tr>
<tr>
<td>A $175.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-network reimbursements</th>
<th>(Copays do not apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$40.00</td>
</tr>
<tr>
<td>Frames</td>
<td>$45.00</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
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<tr>
<td>Bifocal Lenses</td>
<td>$60.00</td>
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<tr>
<td>Trifocal Lenses</td>
<td>$80.00</td>
</tr>
<tr>
<td>Lenticular Lenses</td>
<td>$80.00</td>
</tr>
<tr>
<td>Elective Contacts in Lieu of Eye Glasses</td>
<td>$175.00</td>
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<tr>
<td>Necessary Contacts in Lieu of Eye Glasses</td>
<td>$210.00</td>
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<table>
<thead>
<tr>
<th>Laser vision benefit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at Lasik Plus locations. For more information, call 1-888-563-4497 or visit us at <a href="http://www.uhclasik.com">www.uhclasik.com</a>.</td>
<td></td>
</tr>
</tbody>
</table>
Staying Healthy

Important to Remember:

Benefit frequency based on a calendar year.

1 Your $175.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30.00, you will have $145.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.

2 Medically necessary contact lenses are determined at the provider’s discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming how much of a reimbursement you can expect to receive before you purchase such contacts.

Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UnitedHealthcare Vision, Attn. Claim Dept., P.O. Box 30978, Salt Lake City, UT 84130. Fax: 248.733.6060

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

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; Worker’s Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials 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.

1 On all orders processed through a company owned and contracted Lab network.

2 Necessary contact lenses are determined at the provider’s discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

3 Once all of your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

4 The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

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### 2017 Bi-Weekly Health & Welfare Employee Rates (Excludes Residents)

#### Medical Plans

<table>
<thead>
<tr>
<th>Rates - Colleagues Earnings LESS than $118,500</th>
<th>TRADITIONAL PPO Medical</th>
<th>HEALTH SAVINGS PPO</th>
<th>ESSENTIAL PPO</th>
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</thead>
<tbody>
<tr>
<td><strong>FULL-TIME (FTE .9 - 1.0)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colleague only</td>
<td>$0.00</td>
<td>NA</td>
<td>$15.00</td>
</tr>
<tr>
<td>Colleague plus spouse/ eligible adult</td>
<td>$150.24</td>
<td>$165.24</td>
<td>$180.24</td>
</tr>
<tr>
<td>Colleague plus child(ren)</td>
<td>$395.85</td>
<td>NA</td>
<td>$208.85</td>
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<tr>
<td>Colleague plus family</td>
<td>$187.80</td>
<td>$202.80</td>
<td>$217.80</td>
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<tr>
<td>**TRADITIONAL PPO MEDICAL</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Colleague * 1 eligible adult-ADDL Imputed Inc.</td>
<td>$315.20</td>
<td>$293.82</td>
<td>$262.80</td>
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#### Dental Plans

<table>
<thead>
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<th>HIGH PLAN</th>
<th>STANDARD PLAN</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td>Part-Time</td>
</tr>
<tr>
<td>Colleague only</td>
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<td></td>
</tr>
<tr>
<td>Colleague plus spouse/ eligible adult</td>
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<td></td>
</tr>
<tr>
<td>Colleague plus child(ren)</td>
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</tr>
<tr>
<td>Colleague plus family</td>
<td>$16.38</td>
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</table>

#### Vision Plans

<table>
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<tr>
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<th>HIGH PLAN</th>
<th>STANDARD PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full/Part Time</td>
<td>Full/Part Time</td>
</tr>
<tr>
<td>Colleague only</td>
<td>$5.08</td>
<td>$3.04</td>
</tr>
<tr>
<td>Colleague plus spouse/ eligible adult</td>
<td>$10.55</td>
<td>$5.58</td>
</tr>
<tr>
<td>Colleague plus child(ren)</td>
<td>$11.07</td>
<td>$5.87</td>
</tr>
<tr>
<td>Colleague plus family</td>
<td>$15.60</td>
<td>$8.10</td>
</tr>
</tbody>
</table>

### Basic Life & AD&D Insurance (Provided by Loyola)

- $25,000
A Reimbursement Account can help save you money. You decide how much money you want to set aside. Trinity, Loyola University Medical Center (LUMC), and Gottlieb Memorial Hospital (GMH) have established the Reimbursement (Flex) Accounts allowing you to use pre-tax dollars to pay for certain out-of-pocket expenses not covered by any other employer-sponsored insurance. By participating in the plan, you pay none of the following taxes on qualifying expenses:

- Federal Income Tax
- State Income Tax
- Social Security Tax

When you enroll for 2017 benefits, you can choose:

- **Health Care Reimbursement – Out-of-pocket medical, dental, prescription, and vision expenses not covered by any other health plan**

- **Please note:** If you choose to enroll in the Health Savings PPO medical plan option, you cannot enroll in Flexible Spending for Health Care ONLY Dependent Care.

- **Day Care Expenses – Amounts paid for the care of dependent(s) that allows you (and your spouse, if you are married) to work**

Plan carefully. Estimate your expenses for the upcoming year before you enroll. That way, you will get maximum tax savings without forfeiting any leftover funds.

You may begin submitting requests for reimbursement, along with the required documentation of expenses incurred, after the date you became an eligible participant in the plan.

You are required to use the FSA Reimbursement Request Form for submitting all eligible expenses to Wage Works. Wage Works forms can be printed from their website along with directions for completing the form. When submitting it, please furnish documentation of expenses incurred either through an itemized statement from the provider, your explanation of benefits form, or ask your doctor, dentist or pharmacist to complete and sign in the section titled Provider’s Signature on the form. The form allows you to list several expenses at once. There is a minimum of $20.00 in expenses before the reimbursement will be processed. Remember to sign the form and attach your supporting documentation.

Whether faxed or mailed, you should always keep a copy of all information submitted for your records.
Staying Healthy
◇ Reimbursement Account

Health Care and Dependent Care Reimbursement Accounts

The Reimbursement Accounts allow you to contribute a pretax part of your earnings to accounts (set up in your name) which will reimburse you for eligible health care and/or dependent care expenses. If you wish to participate, you must re-enroll each year, and you must decide the amount to be deposited into each account. The maximum amount you may deposit in a Health Care Account is $2,550 and Dependent Care Account is limited to $5,000.

Health Care

Many different health care expenses are eligible for reimbursement from your Health Care Reimbursement Account, including:

- health and dental expenses not otherwise paid by insurance, including deductibles and co-payments;
- many health care expenses that are not covered under insurance;
- any expenses considered as “deductible” health care expenses by the Internal Revenue Service;
- expenses must be incurred by you, your spouse or your eligible dependents;
- expenses must be incurred during the plan year in which you are enrolled in the Reimbursement Account;
- you cannot deduct reimbursement expenses from your income taxes;
- no over-the-counter drugs are eligible for reimbursement.

Dependent Care

The Dependent Care Reimbursement account is designed to pay for the care of a dependent child or dependent adult so you can work. Eligible expenses include:

- In-home care
- Care at someone’s home
- Nursery or preschool tuition
- After-school care
- Dependent care centers
- Summer day camps, if the cost compares reasonably with other alternatives.

You will need to provide detailed information about your dependent care provider, including names, addresses and Social Security number or tax identification number. Without this information, you cannot receive reimbursement.

Your Dependent Care Reimbursement Account has a few important limitations:

- Care for your dependents (who reside in your home for at least eight hours a day) must be necessary in order for you and your spouse (if married) to work
- Eligible dependents are defined as children under age 13, or a spouse or legal dependent of any age who is physically or mentally incapable of self-care
- Dependent care, such as private baby-sitting, may not be provided by someone who can be claimed as your dependent for tax purposes, such as an older son or daughter
- If dependent care services are provided at a day care center, the center must comply with applicable state and local laws and licensing requirements
- Reimbursement is limited each year to your annual earnings, your spouse’s annual earnings or the federal limit, whichever is less. Your account may not exceed $5,000 (or $2,500 if you file your income tax as “married, filing separately”)

You may elect to enter, exit or change your commitment if you experience one of the following events:

- Change in legal marital status (marriage, divorce, death of spouse)
- Change in the number of tax dependents (birth of child, placement for adoption)
- Employment status change for you, your spouse or dependent
- Dependent satisfies or ceases to satisfy eligibility requirements
- Change in cost of coverage of Dependent Care

A status change can be made only if it is consistent with the change in family or employment status.

Questions can be directed to Wage Works:

1-877-924-3967
### FSA Eligible Health Care Expenses

- Acupuncture
- Alcoholism Treatment
- Ambulance
- Artificial Limb
- Autoette/Wheelchair
- Bandages
- Braille Books and Magazines
- Chiropractor
- Christian Science Practitioner (for medical care)
- Coinsurance
- Crutches
- Deductibles
- Diagnostic Services
- Disabled Dependent Medical Care
- Drug/Alcohol Addiction Treatment (including lodging and meals, if necessary for treatment)
- Drugs and Medicines (prescribed by a physician)
- Durable Medical Equipment
- Guide Dog
- Hearing Aids and Hearing Exams
- Home Care
- Hospital Services
- Inpatient care for treatment of mental or physical handicap
- Laboratory Fees
- Lead Based Paint Removal (to prevent a child who has, or has had, lead poisoning from eating the paint would qualify)
- Learning Disability counseling (If prescribed by a physician)
- Lodging Essential to Medical Care (e.g. out of town hotel stay to see a specialist to treat a medical condition)
- Maternity Care and Related Services
- Medical Services (Physician, Surgeon, Specialists)
- Medicine prescribed by a physician
- Mentally Disabled, Special Home for Nursing Services (in home if recommended by physician)
- Operations
- Organ Donor’s Medical Expense and Transportation
- Osteopath
- Oxygen
- Prosthesis
- Psychiatric Care
- Psychoanalysis
- Psychologist
- Routine Physical Exam-Wellness Visit, Well Woman Exam
- Special Education (with physician’s recommendation payments made for a mentally impaired or physically disabled person)
- Special Medical Equipment such as wheelchairs, crutches, and orthopedic shoes
- Sterilization
- Smoking Assist Programs
- Surgery
- Telephone/Television for the Hearing Impaired
- Therapy
- Transplants
- Transportation Essential to Medical Care (e.g. taxi, bus, train fare to physician’s office)
- Vasectomy
- Weight-loss Program Prescribed by a Physician as Part of a Treatment Program
- Wig (to replace hair loss due to disease)
- X-rays

### Covered Dental Expenses

- Crowns
- Dentures
- Orthodontics (braces, etc.)
- Preventative and basic procedures (e.g. Teeth cleaning, exam)
- Root canals
- Tooth extractions
Staying Healthy

Reimbursement Account - Eligible Expenses and Limitations

Eligible Eye Care Expenses
Optometric services and medical expenses for eyeglasses and contact lenses needed for medical reasons are reimbursable. Eye exams and expenses for contact lens solutions are also reimbursable. However, premiums for contact lens replacement insurance are not reimbursable. Other vision services that are covered include:

- Contact lens cases
- Corrective swim goggles
- Eye charts
- Eyeglass cases
- Eyeglass cleaning supplies such as cleaning cloths
- Reading glasses
- Eyeglass repair or repair kits
- Safety glasses when the lenses correct visual acuity
- Sunglasses or sunglass clips when the lenses correct visual acuity
- Vision shaping

Eligible OTC Medication Expenses That Require a Physician's Prescription
Section 9003 of the Affordable Care Act established a new uniform standard for medical expenses. Effective January 1, 2011, distributions from health FSAs and HRAs will be allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription.

Starting January 1, 2011, eligible expenses that will require a physician's prescription for reimbursement may include, but are not limited to:

- Acetaminophen
- Acne products
- Allergy products
- Antacid remedies
- Antibiotic creams/ointments
- Anti-fungal foot sprays/creams
- Aspirin
- Baby care products
- Cold remedies (including shower vapor tabs and vapor units)
- Cough syrups and drops
- Eye drops
- Ibuprofen
- Laxatives
- Migraine remedies
- Motion sickness
- Nasal sprays
- Pain relievers
- Sleep aids
- Topical creams for itching, stinging, burning, pain relief, sore healing or insect bites

Eligible OTC Medication Expenses That Do Not Require a Physician's Prescription
Items that will continue to be eligible without a physician's prescription after January 1, 2011 include, but are not limited to:

- Band aids
- Bandages and wraps
- Braces and supports
- Catheters
- Contact lens solutions and supplies
- Contraceptives and family planning items
- Denture adhesives
- Insulin and diabetic supplies
- Diagnostic tests and monitors and first aid supplies, peroxide and rubbing alcohol
Staying Healthy

Reimbursement Account - Eligible Expenses and Limitations

Items Not Eligible for FSA Reimbursement

Adoption - the cost of the adoption itself is not covered, however health-related expenses such as physicals for the adoptive parents and pre-adoption counseling may be covered.

Age Management Systems (Cenegenics)

Annual medical contract fees for exclusive provider care.

Breast Pump, Shields, Gel Pads

Clothing

Cosmetic Procedures

Cushions

Dental bleaching or any other teeth whitening

Dental Enamel Micro-Abrasion

Domestic help fees (for services of a non-medical nature)

Driving Lessons

Electric toothbrush replacement brushes

Electrolysis or hair removal

Facial Tissues, Antiviral

Finance charges

Fluoride - Expenses paid for over-the-counter fluorides such as toothpaste with fluoride, or fluoride mouth wash or rinse

Glycerin Shakes

Hair loss treatments (non-prescription) such as over-the-counter medications are not covered. However, prescription medications prescribed by a physician to treat a medical condition are covered.

Hair transplant

Health club dues/memberships, for general well-being unless part of a medically prescribed regimen to treat a specific condition. Physician’s diagnosis letter required.

Insurance premiums of any kind. (See exceptions for HRA and HSA.)

Interest

Lactation Consultation

Laetrile, even if prescribed by a Physician

Late charges

Late payment interest

Lens replacement insurance

Marijuana, even if prescribed for medicinal purposes

Massage therapy for general well-being, unless accompanied by a physician’s diagnosis letter

Medicine flavorings

Missed appointment fees

Over-the-counter items which are items not categorized as a medicine or drug and may include, but are not limited to, nail clippers, pumice stones, feminine hygiene products, etc., are not reimbursable, unless accompanied by a physician’s diagnosis letter. Over-the-counter toiletries or personal hygiene items which may include, but are not limited to shampoo, toothpaste, conditioners, hand creams, deodorant, shaving cream, razors, dental floss, body powders, hair gels/sprays, make-up, nail polish accessories, soap, mouthwash, etc., are not reimbursable.

Pastoral Counseling

Personal Trainer

Physical therapy treatments for general well-being

Pill bags

Postage

Pre-seed moisturizers

Saddle Soap

Savings Club

Shampoo that is non-medicated

Spider vein therapy such as with sclerosing agent injections are considered cosmetic. However, if the therapy is for other than a diagnosis of spider vein therapy the charges are reimbursable when accompanied by a physician’s diagnosis letter.

Supplements - taken for general well-being.

Tanning lotions without sun protection

Tips paid for taxi fares, etc.

Ultrasound - 4D/Elective

Union dues

Vitamins taken for general well-being

Warranties

Weight loss program food or convenience items such as water bottles

Weight loss machines
Staying Healthy

Reimbursement Account - IRS Rules

IRS rules to remember

Keep these rules in mind as you decide whether or not to participate in a Reimbursement Account:

• The Health Care Spending Account (HCSA) has a two-and-a-half month grace period. You can submit eligible claims for expenses incurred through March 15 of the new year for reimbursement of the prior plan year account balance. Be sure to use it by March 15 and submit your claims to WageWorks so they are postmarked on or before March 31, because you’ll be required to forfeit any amounts still in your account after that.

• For the Dependent Care Account, according to IRS rules, any money left in your account on December 31st cannot be returned to you or carried over to the following year. In other words, you must “use it or lose it”.

• Money in your Dependent Care Account can be used only to pay for expenses that you incur during the calendar year you are enrolled in the plan.

• You cannot transfer money between accounts.

• Expenses reimbursed through these accounts cannot be claimed as deductions or credits when you file your income tax return.

• If you terminate employment, your benefits end.

Remember...

Reducing your taxable income may affect your future Social Security Benefits.

The IRS will not allow you to take the Dependent Care Tax Credit for expenses reimbursed through your FSA account.

Depending on your personal situation, the Dependent Care Tax Credit may be more advantageous than the Pre-Tax Flexible Spending Account.

Consult your tax advisor.

Flexible Spending Accounts - A Pre-Tax Savings

<table>
<thead>
<tr>
<th></th>
<th>Without FSA</th>
<th>With FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Pay</td>
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<tr>
<td>Pre-Tax Health FSA</td>
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<tr>
<td>Pre-Tax Dependent FSA</td>
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<tr>
<td>Taxable Income</td>
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<td>Medical Expenses</td>
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<tr>
<td>Dependent Expenses</td>
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<tr>
<td>Spendable Income</td>
<td>$18,523</td>
<td>$20,446</td>
</tr>
</tbody>
</table>

Estimated Savings = $1,923!

Actual savings will vary based on your individual tax situation.
Staying Healthy

◊ FSA Debit Card

FSA Debit Card IIAS Compliant Merchants

The four retailers listed below have adopted IIAS (Inventory Information Approval System). This system automatically identifies FSA eligible merchandise, which has a unique indentifying number, as items are scanned during the checkout process. At Wal-Mart for example, once all items have been scanned, a total is displayed for the entire transaction showing both FSA and non-FSA merchandise. If the customer wishes to use an FSA card for payment of FSA eligible merchandise, they can simply swipe their card at the debit reader and then pay for the non-FSA merchandise with another form of payment.

- Walgreens
- Wal-Mart
- Sam’s Club
- Drugstore.com

The merchants below will have the IIAS system in place. You will still be required to submit receipts for purchases made at retailers not on this list. Regardless of where you shop, we do advise you to keep all receipts for IRS purposes.

<table>
<thead>
<tr>
<th>A&amp;P</th>
<th>Dominick’s</th>
<th>Jewel</th>
<th>Shop &amp; Save</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACME</td>
<td>Farm Fresh</td>
<td>Kerr Drug</td>
<td>ShopKo Stores/Express</td>
</tr>
<tr>
<td>Albertson’s</td>
<td>Food Basics</td>
<td>Kroger</td>
<td>Shoppers</td>
</tr>
<tr>
<td>Balls Food Stores</td>
<td>Food Lion</td>
<td>Lin’s</td>
<td>Star Market</td>
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<tr>
<td>Biggs</td>
<td>Genuardi’s</td>
<td>Long’s Drug Stores</td>
<td>Stop &amp; Shop</td>
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<tr>
<td>Bloom</td>
<td>Giant Eagle</td>
<td>Macey’s</td>
<td>Sunflower</td>
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<td>Bottom Dollar Food</td>
<td>Giant Food</td>
<td>OSCO</td>
<td>SuperFresh</td>
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<tr>
<td>Brookshires/Super 1 Foods</td>
<td>Giant Food Stores</td>
<td>Pak’n Save Foods</td>
<td>Super 1 Pharmacies</td>
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<tr>
<td>Buehler Food Markets</td>
<td>Hannaford</td>
<td>Pavilions</td>
<td>Sweetbay</td>
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<td>C. &amp; P.</td>
<td>Harris Teeter, Inc.</td>
<td>Price Chopper</td>
<td>Target</td>
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<tr>
<td>CVS/Pharmacy</td>
<td>Harvey’s</td>
<td>Randalls</td>
<td>Tom Thumb</td>
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<tr>
<td>Cub Foods</td>
<td>H-E-B</td>
<td>Reid’s</td>
<td>Tops Markets</td>
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<tr>
<td>Dan’s</td>
<td>Hen House Markets</td>
<td>Rite Aid</td>
<td>Vons</td>
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<tr>
<td>Dick’s</td>
<td>Hornbachers</td>
<td>Rosauers</td>
<td>Waldbaum’s</td>
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<tr>
<td>Dierbergs Markets</td>
<td>Hy-Vee Drug Stores</td>
<td>Safeway</td>
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<tr>
<td>Discount Drug Mart</td>
<td>Hy-Vee Food Stores</td>
<td>Shaws</td>
<td></td>
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</tbody>
</table>

This is not an all-inclusive list as the number of retailers adopting the IIAS system will continue to grow. Ask the retailer if they are IIAS compliant before making your purchase if you are not sure. Also note that most smaller pharmacies have not yet adopted the IIAS system.

Please Note: After December 31st all claims for service during that calendar year cannot be paid with the debit card. You will have to submit the claim for service prior to December 31st on a paper form.
Your Basic Life, AD&D

The Basic Life, AD&D and LTD programs are provided in the event of your death or a catastrophic illness. Loyola University provides this benefit at no cost to you.

Am I eligible for life insurance, AD&D and Disability coverage?

All House Staff Members contracted with Loyola University Medical Center are eligible for life, AD&D and Disability benefits. House Staff Members on rotation are entitled to keep in force their group insurance policies carried through Loyola University Medical Center.

When are all benefits effective?

House Staff Members are covered effective the first day of employment. This life insurance carrier is The Hartford.

Basic Life and AD&D insurance

Basic Life and Accidental Death and Dismemberment insurance is provided to House Staff Members in the amount of $25,000 for each plan. Loyola provides this insurance at no cost to you.
Direct Deposit

Loyola/Gottlieb offers direct deposit of your paycheck to your bank or credit union. If you choose direct deposit, complete the direct deposit form that is available in the Human Resources Department. Please submit a voided check or a direct deposit sign up form directly from your bank. It will take two pay periods or more before the direct deposit will be effective. Also available (Loyola colleagues only) if you are on direct deposit, is receipt on-line of your direct deposit paycheck sent via email. You can have your paycheck stub sent to any e-mail address that you choose. Check box on direct deposit form and indicate your e-mail address. Paychecks can also be viewed via the portal on Loyola.wired and logging into lawson.

Loyola University Colleagues Federal Credit Union

A credit union is a unique financial institution yet is under the same regulations as a bank. Formed by a group of people with a common link, like their profession or place of work, a credit union is run by its members. The initial capital to start the credit union comes from the founding members who pool their own money as savings and make low-cost loans to each other.

Loyola’s credit union started in just this way, with the mutual self-interest of its members at its heart. The sole purpose of the credit union is to meet the financial needs of its members.

Joining: Membership is open to anyone who works for or is supervised by Loyola anywhere. Included are full and part-time faculty and staff, colleagues, students as well as Trinity affiliates or contractors, plus their immediate families. A share account may be opened with a minimum balance of $25.00. You may authorize payroll deduction for direct deposit into your CU account. Membership forms may be obtained in Loyola/Gottlieb HR office or at the Credit Union (located at the Lower Level of Maguire Building). Your Credit Union account is insured for up to $250,000.00 through the National Credit Union Administration Insurance Fund, an agency of the Federal government.

A Loyola Credit Union representative is available at 708-216-4500. Their website is www.luefcu.com

Services

- Direct Payroll Deposit
- Savings Account
- Free Checking
- ATM / Visa Credit Cards
- CD
- IRA
- Special Savings Clubs
- Financial Planning
- Online Banking
- Loan options
  - Signature
  - New/used car
  - Boat
  - Motorcycle
  - Credit Revival
  - Pledge (secured)
- Discount tickets
  - Local movie theaters
  - Great America/Six Flags
- Home and Auto Insurance
- Free Notary for members
- Friendly, personal service
Family & Money Matters

Loyola University Medical Center Education Assistance Benefit

Colleague Graduate Tuition Benefit*

The annual maximum for a full-time colleague, with one year of service, is $10,000 toward tuition to attend graduate programs at Loyola University Chicago.

Additionally, colleagues are required to:

- pursue a graduate degree directly related to their current position or one they are likely to hold in the three years following graduation.
- obtain administrative approval from their Vice President and Human Resources, and
- commit to working at LUMC for three years after the completion of the graduate program.

In order to receive the graduate program tuition benefit, colleagues will need to sign a letter of agreement based upon the requirements, as well as complete the tuition application form and receive admission approval on their graduate degree selected THREE WEEKS PRIOR to beginning the class.

Educational Assistance: benefits will be taxed according to IRS Regulations

Dependent/Spouse Tuition Benefit*

Dependants of colleagues satisfying eligibility requirements (five years continuous full time employment immediately prior to applying for the benefit and accepted for admission at LUC) that are currently enrolled and were enrolled by Fall semester 2009 will receive full tuition reimbursement under the current policy through 2013 or age 24 (earliest date).

All other colleagues and all new colleagues

Dependants of current and new colleagues satisfying current eligibility requirements (five years continuous full time employment immediately prior to applying for the benefit and accepted for admission at LUC) that enroll after Fall semester 2009 will be eligible for 50% tuition reimbursement after any financial aid/awards up to a maximum of $15,000 per student per year. Reimbursement is available for four years or to age 24 (earliest date). This benefit is not available to part-time colleagues.

Educational Assistance: benefits will be taxed accordingly to IRS Regulations

*See HR policy B-2 on Loyola.wired for complete details about tuition reimbursement. As of January 1, 2009, all colleague and dependent tuition will be administered per this policy. Please note that LUMC benefits are determined and calculated pursuant to applicable LUMC policies and procedures in effect from time to time and are, at all times, subject to alteration, revision or discontinuation by LUMC.

Gottlieb Tuition Benefits

Personal and professional growth are important values. To provide colleagues with support and reimbursement for continuing education and career advancement we encourage and provide reasonable reimbursement for degree programs and/or college courses which are mutually beneficial for the colleague and the hospital. Full-time and part-time colleagues who work at least 40 hours per pay period are eligible for the plan effective with their date of employment. For more information, call 1-708-216-9408, or visit the Gottlieb Intranet, gott.news, for more information.
Loyola/Gottlieb offers our colleagues an easily accessible and confidential way to take the first steps toward resolving almost any kind of personal challenge or conflict. Generally, the problems that people bring to EAP fall into such broad categories as:

- Family concerns
- Legal matters
- Financial difficulties
- Job stress
- Grief
- Depression
- Interpersonal conflicts at work or at home
- Addiction to alcohol or drugs
- Self-esteem

By helping individuals solve problems that can interfere with their personal and professional lives, the EAP is one of the ways that Loyola/Gottlieb demonstrates its commitment to, and investment in, its colleagues. If you are a full or part-time colleague, you can make an appointment by calling 1-708-216-4129.

The Consultation & Referral Service is designed to take the legwork out of your search and provide you with information to be a better consumer. Since you can best determine the personal compatibility of a particular provider the Workplace Solutions provides you with a selection of resources that have been screened to meet your criteria. The comprehensive database includes a wide spectrum of work/life sources. Some services provided are:

- Full & Part-time Day Care, In-Home Care, Back-up Care
- School Age Programs, Camps, Tutoring Programs
- Elder Care Programs, In-Home Care Options
- Adoption Assistance, Family Legal Issues, Convenience Services

You can call 1-866-849-1686 for additional information or to use this service. For on-line access to information go to: www.worklifeexpress.com

Username: lumc001       Password: worklife

We are happy to announce in addition to our Daycare Referral Program we also have a new benefit of an on-site daycare center through Gottlieb. Gottlieb Child Development Center has openings for childcare services for children aged 6 weeks through Kindergarten. As a Loyola colleague you are eligible for colleague rates for childcare services. The center is located at 905 W. North Avenue and is open from 6:30 am to 6:00 pm. In order to use the Center a child must attend the center no less than 3 days per week. There are six age group levels in the childcare classrooms. Daycare Handbooks and rates are available in Gottlieb Human Resources. You can call the center directly at (708) 681-7871 if you have any questions or would like a tour of the facility.

Many of us are also at a loss at times if we need Elder Care. Gottlieb also offers an Elder Daycare benefit by the day with a minimum attendance of two days per week. You can reach the Gottlieb Adult Day Care at 708-681-7700 for additional information.
Family & Money Matters
◊ Group Legal

The Hyatt Legal Plans, Inc. provides you and your family access to a network of attorneys who can provide a wide range of professional legal services, including wills, document review and preparation, debt collection defense and personal bankruptcy, court appearances, family matters and real estate transactions.

You pay the entire cost of this benefit, but it is available to you at low group rates through Trinity’s purchasing power. And your payments are made through convenient payroll deductions.

If you use a network attorney, the plan pays the entire cost for covered legal services, up to the plan’s maximums. There are no deductibles, copayments or claim forms. If you use an attorney who is not in the network, the plan pays a portion of your expenses, and you pay the remaining costs.

- Family Matters: uncontested divorce, uncontested adoption, name change, and prenuptial agreements
- Wills, Power of Attorney, Living Will, and Trusts
- Real Estate Matters: sale, purchase, refinancing of primary residence, eviction & tenant problems (tenant only),
- Document Preparation: mortgages, notes, demand letters, affidavits, and elder law matters
- Defense of Civil Law suits: administrative hearings, civil litigation defense, and incompetency defense
- Immigration Assistance
- Traffic and Criminal Matters: juvenile court defense, restoration of driving privileges, and traffic ticket defense (No DUI)
- Unlimited Telephone Advice and Office Consultation

- Your per pay period cost
  Colleague only: $5.12
  Colleague plus family: $6.97

Certain types of services are excluded. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving the employer, MetLife® and affiliates, and plan attorneys
- Matters in which there is a conflict of interest between the colleague and spouse or dependents in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm and business matters, including rental issues when the Participant is the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits

The new website password is 2400010 for Single Coverage and 2420010 for Family Coverage.

For more information on Hyatt Legal Plans, call Hyatt’s Client Service Center at 1-800-821-6400, or visit their web site at www.legalplans.com and enter password 2400010 for Single Coverage and 2420010 for Family Coverage for details.
Planning For The Future

• Disability Short & Long Term

Short Term Disability - Employer Paid Benefit

For non-management colleagues: You’re eligible for short-term disability coverage equal to 50 percent of base pay if you’re a regularly-scheduled, active full- or part-time colleague with 40 or more budgeted hours per pay period. You become eligible to receive benefits as of the first day of the month following 30 days of continuous active employment. Benefits begin after you are unable to work for at least 14 calendar days due to illness or hospitalization, and continue for up to 180 days (this includes the waiting period).

NOTE: no election is required to receive this benefit.

Long-Term Disability - Plan Highlights and Benefit amount

For non-management colleagues: You’re eligible for long-term disability (LTD) coverage equal to 50 percent of base pay (subject to a maximum monthly payment) if you’re a regularly-scheduled, active full- or part-time colleague with 40 or more budgeted hours per pay period. Benefits begin six months after your disability period begins.

You have the option to “buy up” LTD coverage to 66-2/3 percent of base pay:

- 50% of pay (employer provided/paid)
- 66-2/3% of pay

<table>
<thead>
<tr>
<th>LTD BUY-UP (NON-MGMT)</th>
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<tbody>
<tr>
<td>66.67% Earnings Replacement</td>
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</tbody>
</table>

Ex. Calculate Coverage - Base earnings = $60K

$60K * 66.67% = $40,000/100 = 400 * .401 = $160.40 / 26 = $6.16 per payck (est.)

Costs for LTD “buy up” are based on your income level, and will be available when you enroll online.

Parking Pre-Tax Account

This plan saves you money when you pay for parking at work on a before-tax basis. Before-tax payroll deductions will cover your parking expenses at a Loyola parking facility each month, so there’s no need to submit parking expenses.

For Loyola parking only

This account can be used only for parking expenses at Loyola. It cannot be used for other costs of commuting to work such as train fare or carpooling.
Planning For The Future

Retirement Savings Plans

CHE Trinity Health Retirement Program

The Retirement Program design was the result of a thoughtful process. The design:

• Provides a meaningful retirement benefit—Investment professionals recommend that employer and colleague savings target 9 percent to 15 percent of your pay annually* (depending on your income) to prepare for your retirement. If you contribute 6 percent of your pay, our retirement design provides you annual savings that vary between 10.5 percent and 13.5 percent of your pay (based on your years of service) when both colleague and CHE Trinity Health contributions are added together.

• Supports lower-paid colleagues—The design provides a core benefit of 3 percent of pay to all who meet eligibility requirements (defined on page 8). In addition, the design includes a minimum benefit (see page 6) that allows our lower-paid colleagues to receive a higher core retirement benefit contribution each year (as a percentage of pay).

• Is predictable and sustainable—Under the 2016 design, the employer matching contribution will not be decided annually. Instead, it will be based on a set formula and will require Board approval to be changed or modified.

• Rewards colleagues with longer service—with higher annual matching contributions.

• Offers consistent benefits across the organization—Bringing all colleagues into one retirement design allows for a consistent benefit offering no matter where you work within CHE Trinity Health throughout your career and supports mobility across the organization.

Eligible Colleague annual contributions will be made up of three components:

1. Employer Core Contributions
2. Employer Service-Based Matching Contributions (if you make contributions)
3. Colleague Contributions

When combined with your personal savings, the CHE Trinity Health Retirement Program provides the tools to assist you in planning for a financially secure retirement. These tools include the CHE Trinity Health core contribution, the CHE Trinity Health 403(b) Retirement Savings Plan, and a non-discretionary employer match. By taking advantage of all of these tools, both you and Trinity Health work together to help financially secure your future.

Retirement income is the amount of income you will need when you retire in order to maintain your current lifestyle. Retirement experts estimate this amount to be approximately 80 percent of your final salary. So, how do you ensure that you have an adequate retirement income when you retire? You start by taking advantage of all of your income sources, including the Trinity Health Retirement Program, to create balanced income sources during retirement.

• Eligibility – All active colleague are covered by the Plan beginning on their date of hire, except: Colleague covered by a collective bargaining agreement that does not provide for participation in the Plan;

• Distributions – FOR DISTRIBUTION QUESTIONS and options, PLEASE CONTACT A Transamerica retirement customer service at 800-394-5240.

Loyola University Medical Center’s Clinical Faculty Retirement Plan

Clinical Faculty Retirement Plan earn retirement benefits under the Clinical Faculty Retirement Program, which consists of:

• CHE Trinity Health Retirement Program
• CHE Trinity Health 403(b) Retirement Savings Plan
• CHE Trinity Health 457(b) Deferred Compensation Plan
• Flex Fund Benefit
Planning For The Future

diamond Retirement Savings Plans

CHE Trinity Health 403(b) Retirement Savings Plan

Pre-Tax Contributions

- **Eligibility** – you may begin contributing to Trinity Health 403(b) Retirement Savings Plan immediately, there is no waiting period.

- **Amount of Contribution** – Auto-Enrollment for Newly Hired Colleagues
  - Colleagues will be automatically enrolled in the Trinity Health 403(b) plan at 2% of pay. Auto-enroll contribution will be 2% with an allocation to a Vanguard Target Date Fund corresponding to the year in which the colleague will attain age 65.

- Colleagues wishing to waive participation in the Trinity Health 403(b)/401(k) Retirement Savings Plan must opt out within a 30 day period. Transamerica will send a letter to new colleagues, describing auto-enrollment, account setup instructions, and opt-out information.

You can contribute to the CHE Trinity Health 403(b)/401(k) Retirement Savings Plan through pretax contributions up to the annual IRS limit. The limit is $18,000 (or $24,000 if you are at least age 50) in 2017 and is indexed annually. Be sure to contribute at least 6% of your Retirement Program Pay to earn the maximum employer match. If you contribute any less, you will miss out on a portion of the matching contribution.

- **Vesting** – You are always 100% vested in your pre-tax contributions.

- **Investing the Contribution** – You decide how your pre-tax contributions will be invested, choosing from investment options provided under the Trinity Health 403(b) Retirement Savings Plan.

Employer Contributions to the CHE Trinity Health 403(b) Retirement Savings Plan

Discretionary Employer Matching Contribution

Employer Core Contribution - You will begin receiving the employer core contribution once you have earned at least 1,000 hours in that calendar year. Your first deposit will be based on Retirement Program Pay for the calendar year earned year-to-date. Subsequent deposits will be made shortly following each pay period.

Service-Based Matching Contribution (if you make a contribution)—For contributions you make to your CHE Trinity Health 403(b)/401(k) Retirement Savings Plan up to 6% of your Retirement Program Pay, you will receive an employer service-based matching contribution, if eligible. You will receive this contribution based on any amount that you contribute. However, if you are eligible and wish to maximize the employer service-based matching contribution, you must contribute at least 6% each calendar year. Your employer service-based matching contribution ranges from 25% to 75% of your contributions (up to a maximum of 6% of your Retirement Program Pay), based on your years of benefit service. If you are scheduled (or budgeted) to work at least 1,560 hours per year as of the first pay period of each calendar year, you will begin to receive the service-based matching contribution to your Transamerica account shortly after your first paycheck of the calendar year. If you are scheduled for less than 1,560 hours per year, you will begin receiving the service-based matching contribution as soon as you earn 1,000 hours in that calendar year. If you become eligible after earning 1,000 hours, your first deposit will be based on Retirement Program Pay earned year-to-date. Subsequent deposits will be made shortly following each pay period.

Timing of match and core contribution.

Your deferrals (pretax contributions) will be deposited shortly after payroll is run. In addition, your core and match will be calculated and deposited shortly following your deferral deposit each pay period.
You must contribute at least 6% of your Retirement Program Pay to your Retirement Savings Account to receive the maximum employer service-based matching contributions. Make sure that you contribute at least 6% in order to maximize the employer matching contribution!

- **Vesting** - Discretionary employer matching contributions are subject to the following vesting schedule:
  - Less than 3 years of service - 0% vested;
  - 3 years of service or more - 100% vested

- **Investing the Contribution** - You decide how your discretionary employer matching contributions will be invested, choosing from investment options provided under the Trinity Health 403(b) Retirement Savings Plan.

Please contact TransAmerica at 800-394-5240 for more information regarding the above benefits.
Your Adoption Assistance Program

The Adoption Assistance Program provides partial reimbursement for the expenses an employee incurs during the adoption process.

What Is Adoption Assistance Benefit?

The adoption assistance benefit reimburses for certain expenses related to a qualified adoption. The program reimburses you up to $4,000 or $6,000 for special needs child.

Expenses will only be paid for adoption of children under the age of 18 or who are physically or mentally incapable of caring for themselves.

The amount is capped at $4,000 per child if both parents are employed by a Trinity Health Organization.

Benefits are payable at 90% for covered expenses up to a maximum of $4,000 or $6,000 for special needs child. Covered expenses, which must be “reasonable and necessary”, for example are:

- Agency fees
- Legal fees
- Court costs
- Maternity cost for the child
- Temporary foster care
- Placement fees
- Transportation costs
- Counseling fees

What Is Not Covered Under The Program?

- Benefits are not payable for adoption of stepchildren and for pre-natal or maternity costs for the birth mother of the adoptive child
- Adoption expenses must be incurred after 1/1/97, the effective date of the program.

Are The Adoption Assistance Benefits Considered Taxable?

The adoption assistance benefit is not subject to federal or Illinois state tax withholding, but is subject to FICA withholding tax.

How Do I Get More Information?

Contact the Benefits Department at 1-708-216-9401 for more information or visit the Loyola website at: www.luhs.org/internal/depts/hr/benefits.htm
Loyola University Health System understands that saving for higher education can be a financial task. The challenge to meet the savings needs for the future can be overwhelming. It requires careful planning and commitment.

As parents and grandparents, you want to be able to provide the benefit of college to your children, grandchildren and yourself. LUHS is offering CollegeBoundfundSM, a flexible, tax-advantaged 529 college savings program managed by Alliance Bernstein. This plan offers:

**TAX-FREE EARNINGS:** No federal income tax is due on earnings while in the CollegeBoundfundSM account.

**TAX-FREE DISTRIBUTIONS:** Distributions for qualified educational expenses are federal income tax free.

**HIGH CONTRIBUTION LIMITS:** You can accumulate up to $385,000 (contribution and earnings) per beneficiary account.

You can sign up for monthly contributions of $50 or more. The enrollment process is online.

The entire enrollment process should take you about 15 minutes to complete. Before you begin, please be sure to have your beneficiary's date of birth and social security number.

Log on to www.corporate.collegeboundfund.com
Select “Company” as your ID Type
Enter the following User ID and Password:

**User ID:** LUHS  
**Password:** 529LUHS

You will be prompted to enter a personal User ID and Password, which you will use during subsequent visits to the site.

Click on “Open Account/Enrollment” and follow the instructions. If you haven't already done so, please take a minute to review the CollegeBoundfundSM Program Description.

Once you have completed the online enrollment process, print and sign two copies of the Enrollment Confirmation. Please keep one for your records, and return the other to CollegeBoundfundSM in the return envelope provided in your enrollment kit. Your account will not be activated until CollegeBoundfundSM receives your signed original Enrollment Confirmation.

If you have questions or want to enroll on paper, call Jim Vermillion or Terry Monroe at Robert W. Baird & Co. in Chicago at **1-800-537-9854** or **1-312-332-5600**

Or you can contact them by e-mail:  
**jvermillion@rwbaird.com** or **tmonroe@rwbaird.com**

If you would like to review their monthly newsletter, Investment Strategy Outlook, you can view on their website at [www.vermillionmonroegroup.com](http://www.vermillionmonroegroup.com)
Planning For the Future
◆ Voluntary Benefits - The Farmington Company

Permanent Life Insurance
Own and control your life insurance.

- Coverage for colleague, spouse, children and/or grandchildren.
- You may cover one of these family members without having to buy a policy on yourself.
- Premiums remain the same and coverage will not reduce as you get older.
- Portable coverage should an colleague leave.
- Favorable underwriting gives colleagues and family members with medical problems a much greater opportunity to qualify for coverage. This opportunity is offered when you first become eligible.

Critical Illness Insurance
Focus on getting better, not on worrying about paying your bills.

- Benefits are paid lump-sum, tax-free directly to you upon diagnosis of a covered critical illness.
- Covered illnesses are heart attack, stroke, end-stage kidney (renal) failure, major organ transplant, permanent paralysis due to an accident, and coronary artery bypass surgery.
- Available for colleague, spouse, and dependent children.
- Dollars are paid in addition to medical and disability benefits.

Cancer Insurance
Enhance your medical coverage and get additional, much-needed dollars.

If you, a family member, co-worker or friend ever had an experience with cancer, you know that even the best medical plan does not cover all of the expenses. The American Cancer Society estimates that over 60% of all costs associated with fighting cancer are non-medical in nature or are not reimbursed by major medical plans.

- Benefits are paid for chemotherapy and radiation.
- Additional dollars are available for travel, hospital confinement, hotel stays, etc.
- These monies are paid directly to you, in addition to medical or disability benefits, and you may use them as you wish.

Lifelock® Identity Theft Protection
Identity theft costs Americans billions every year. Protect your good name today.

Works 24/7 to safeguard your personal information both online and off.

Available to Trinity Health colleagues at a 40% discount off the typical retail rates.

Current LifeLock members: You are eligible for the special Trinity Health rates by calling The Farmington Company at 1-866-251-9529.
Voluntary Benefits - The Farmington Company

Planning For the Future

Accidental Death & Dismemberment

Affordable coverage in the event of death or injury due to an accident.

- Coverage is guaranteed issue up to 10 times your salary.
- These are just a few of the benefits payable as the result of a covered accident: loss of life, paralysis, coma, loss of speech and hearing, loss of use of a limb or sight, and seatbelt and airbag benefit. Includes protection for felonious assault and violent crimes.
- You can elect coverage for yourself, your spouse, and/or your dependent children.
- HIV occupational accident insurance.
- Access to Cigna’s Travel Assistance Program.

Auto/Homeowner’s Insurance

Favorable rates and the convenience of payroll deduction.

Auto plan details:

- No down payment required.
- Claims reporting 24 hours per day, 365 days per year.
- Local adjuster network.
- Portable coverage should an associate leave.
- Quotes are run by up to eight companies - all with pre-negotiated discounts.
- One-year waiting period.

Residence plan details:

- Home, condominium, and/or apartment coverage.
- Guaranteed replacement cost coverage available.

Pet Insurance

They’re family and deserve the best care, too.

- Reimbursements are paid directly to pet owners for a comprehensive list of veterinary services (i.e., spaying, neutering, and confinement of your pet at a veterinarian’s premises or hospital).
- $50 per incident deductible. Claims are processed within 10 days.
- Choice of any veterinarian - no pre-authorization required.

Hospital Indemnity

Additional protection against the rising cost of hospitalization.

- Plan pays a daily benefit, up to 180 days if you, or a covered family member, are confined to a hospital for a covered condition.
- Benefits paid for covered surgeries, anesthesia, physician visits, laboratory fees, X-rays and injections/medications.
- Helps cover out-of-hospital prescription drugs.
- Benefit paid for well baby care visits up to four times per year.
Planning For the Future

COBRA

Initial COBRA Notice

This notice contains important information about the right to COBRA continuation coverage. COBRA coverage is a temporary extension of coverage that applies in certain situations when a loss of health coverage would otherwise occur. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985.

This notice generally explains COBRA continuation coverage, when it may become available, and what to do to protect the right to receive it. If you have any questions about this notice or the Plan in general, you can contact:

Loyola University Medical Center
Human Resources,
2160 South 1st Avenue
Maywood, Illinois  60153
Phone 1-708-216-9401
Fax 1-708-216-4918

Trinity has contracted with Wage Works (“the COBRA Administrator”) to perform many of the administrative tasks required by federal law. This Initial Notice of COBRA Rights indicates when you should contact the COBRA Administrator, rather than Trinity, for information or assistance.

Direct all questions and inquiries to our COBRA Administrator, at:

Wage Works
COBRA
1100 Park Place, 4th Floor
San Mateo, CA 94403
Phone 1-708-216-9401

The group health benefits to which this notice applies are provided under the following plan(s):

- The Loyola University Medical Center / Gottlieb Memorial Hospital Health Insurance Plan
- The Loyola University Medical Center / Gottlieb Memorial Hospital Dental Insurance Plan
- The Loyola University Medical Center / Gottlieb Memorial Hospital Health Care Flexible Spending Account Plan
- The Loyola University Medical Center / Gottlieb Memorial Hospital Vision Plan

Each of these plans is referred to in this notice as the “Plan,” so you should read this notice as if it applied separately to each Plan. The word “participant” refers to any colleague or former colleague of Trinity who is or was covered under health benefits provided by the Plan.

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<thead>
<tr>
<th>Qualifying Events</th>
<th>Qualified Beneficiaries Could Be</th>
<th>Maximum Continuation Period</th>
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<tbody>
<tr>
<td>Termination*</td>
<td>Colleague, Spouse, Dependent child(ren)</td>
<td>18 months</td>
</tr>
<tr>
<td>Reduction in Hours (resulting in loss of coverage)</td>
<td>Colleague, Spouse, Dependent child(ren)</td>
<td>18 months</td>
</tr>
<tr>
<td>Divorce or Legal Separation</td>
<td>Spouse, Dependent child(ren)</td>
<td>36 months</td>
</tr>
<tr>
<td>Death of Loyola/Gottlieb Colleague</td>
<td>Spouse, Dependent child(ren)</td>
<td>36 months</td>
</tr>
<tr>
<td>Entitlement to Medicare</td>
<td>Spouse, Dependent child(ren)</td>
<td>36 months</td>
</tr>
<tr>
<td>Child loses dependent status</td>
<td>Spouse, Dependent child(ren)</td>
<td>36 months</td>
</tr>
</tbody>
</table>

* Other than reason of gross misconduct

Under the Plan, participants can elect coverage under the following health benefits:

Health
- Trinity Blue Cross and Blue Shield PPO Plans

Dental
- Trinity Dental Plan PPO Plans

Vision
- Trinity United Health Care Vision Plans

Flexible Spending Accounts
- Trinity Health Care Flexible Spending Account Plan
Planning For the Future

◊ COBRA

What Is Cobra Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage that may become available when coverage would otherwise end because of a life event known as a “qualifying event.”

Qualified Beneficiaries

A participant, the participant’s spouse (as defined in federal law), and the participant’s dependent children can be qualified beneficiaries who are entitled to elect COBRA coverage if they lose coverage under the Plan because of a qualifying event. After a qualifying event has occurred (and, if applicable, proper notice of the qualifying event has been given), COBRA coverage must be offered to each of these “qualified beneficiaries” that would lose Plan coverage as a result of that qualifying event.

To a Participant

If you are a participant, you will be entitled to elect COBRA if you have a loss of coverage under the Plan because one of the following events occurs:

- Your hours of employment with Trinity are reduced to a level that renders you ineligible for benefits.
- Your employment with Trinity ends for any reason other than your gross misconduct.

To a Participant’s Spouse

If you are the spouse of a participant, you will be entitled to elect COBRA if you have a loss of coverage under the Plan because any of the following events occurs:

- Your spouse dies.
- Your spouse’s hours of employment with Trinity are reduced.
- Your spouse’s employment with Trinity ends for any reason other than his or her gross misconduct.
- You become divorced or legally separated from your spouse, but only if notice of the divorce or legal separation is given to us as specified later in this Notice in the section entitled “In Some Cases Qualified Beneficiaries Are Required to Give Notice.”

To a Participant’s Dependent Child

If you are the dependent child of a participant, you will be entitled to elect COBRA if you have a loss of coverage under the Plan because any of the following events occurs:

- The participant that is your parent dies.
- The participant that is your parent has a reduction in hours of employment with Trinity.
- The participant that is your parent terminates employment with Trinity for any reason other than his or her gross misconduct.
- The participant that is your parent becomes divorced or legally separated, but only if notice of the divorce or legal separation is given as specified later in this Notice in the section entitled “In Some Cases Qualified Beneficiaries Are Required to Give Notice.”
- You stop being eligible for coverage under the Plan as a “dependent child” of the participant, but only if notice of the event making you ineligible is given as specified later in this Notice in the section entitled “In Some Cases Qualified Beneficiaries Are Required to Give Notice.”

When Will COBRA Become Available?

In order for COBRA coverage to become available, a qualified beneficiary (as described above) must have a loss of coverage due to certain events (listed below). When one of these events causes a qualified beneficiary to lose coverage under the Plan it is referred to as a “qualifying event.”

Are Qualified Beneficiaries Required To Give Notice Of A Qualifying Event?

The type of qualifying event determines whether a qualified beneficiary is required to give notice of the qualifying event.

In Some Cases Qualified Beneficiaries Are Required to Give Notice.

If a qualifying event is a participant’s divorce or legal separation, or a dependent child’s losing eligibility for coverage under the Plan, COBRA will not be offered (or available) unless written notice of these events is provided to Loyola University/Gottlieb Memorial Hospital.

The notice must be given within 60 days after the later of the event (the divorce or legal separation, or the event causing the dependent child’s ineligibility) or the date the Plan says coverage will end because of the event. If notice is not provided within the 60-day period, COBRA coverage will not be available as a result of that event.

Also, any claims paid by the Plan after the date coverage should have ended must be refunded to the Plan.

In Other Cases, No Notice is Required.
Planning For the Future

◊ COBRA

If a qualifying event is a participant’s termination of employment, reduction in hours of employment or death, you are not required to give notice of the event in order for COBRA coverage to be offered. COBRA coverage will be offered to the qualified beneficiaries with respect to these events even if no notice is provided.

How Is COBRA Elected?
When it is determined that a qualified beneficiary should be offered COBRA, the offer is made by sending an election notice. The election period ends 60 days after the date of the election notice or, if later, the date the Plan terms call for the qualified beneficiary to lose coverage because of the qualifying event. The postmark date on the envelope in which the election of COBRA coverage is sent will be deemed the date the election was made.

If your COBRA coverage election is not made before the end of the 60-day election period as described above, you will lose the right to obtain COBRA coverage and your health coverage under the Plan will end.

Independent Election Rights
Each qualified beneficiary losing coverage due to a qualifying event (and for whom any required notice has been provided) will have an independent right to elect COBRA coverage, meaning that each may elect COBRA coverage even if other family members do not.

Effect of Other Coverage or Medicare
Qualified beneficiaries who are entitled to elect COBRA may do so even if covered by another group health plan or Medicare prior to the election date. COBRA coverage will terminate automatically if, after electing COBRA, a qualified beneficiary first becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after the qualified beneficiary is no longer subject to any exclusion or limitation applicable under that coverage that applies to a preexisting condition of the qualified beneficiary).

How Long Can COBRA Coverage Be Available?
Limited Availability of Health Care/FSA COBRA coverage under the FSA will terminate at the end of the plan year in progress at the time of the qualifying event. You will not be able to make an election for the next plan year. All of the usual rules for the FSA regarding submitting claims, forfeiting unused balances, etc. will apply during the COBRA period.

If a qualified beneficiary elects COBRA under the FSA, the COBRA coverage will apply to all of the qualified beneficiaries who lost FSA coverage due to the same qualifying event as the electing qualified beneficiary, unless the election form specifies otherwise. Each qualified beneficiary has separate election rights, and each could elect separate COBRA coverage under the FSA to cover that beneficiary only, with a separate FSA annual limit and a separate premium.

If the qualifying event was a participant’s termination of employment or reduction in hours of employment, the maximum COBRA coverage period for health benefits other than the FSA generally is 18 months.

Events Potentially Extending an 18-Month Maximum COBRA Coverage Period
The 18-month maximum COBRA coverage period that usually applies when a termination of employment or reduction in hours qualifying event occurs can be extended in three situations.

Medicare Entitlement Before Termination of Employment or Reduction in Hour
If a participant becomes entitled to Medicare during the 18 months before a qualifying event consisting of the participant’s terminating employment or reducing hours, an extended maximum COBRA coverage period can apply to that participant’s spouse and dependent children who become qualified beneficiaries due to the termination of employment or reduction in hours. The participant’s maximum COBRA coverage period will remain 18 months in this case, but the other qualified beneficiaries will have a maximum continuation period that ends 36 months after the date of the participant’s Medicare entitlement. If, for example, a participant became entitled to Medicare on July 1, 2016 and terminated employment on September 15, 2016:

- The participant’s maximum COBRA coverage period would end on April 30, 2018.
- The participant’s spouse and dependent children would have a maximum COBRA coverage period that ends on September 30, 2019.
Planning For the Future

COBRA

Social Security Administration Determination of a Qualified Beneficiary's Disability

- The 18-month maximum COBRA coverage period (or the period of coverage resulting from Medicare entitlement as described in the preceding paragraph) may be extended to a total of 29 months from the date of termination of employment or reduction in hours if a qualified beneficiary receives a Social Security Administration determination that the qualified beneficiary is disabled. This extension will apply only if the Social Security Administration determines that you (or another individual who is entitled to COBRA coverage because of the same qualifying event) were disabled at any time during the first 60 days of COBRA coverage, you notify the COBRA Administrator in a timely fashion, and you remain disabled throughout the extension period. For this extension to be available, the COBRA Administrator must be notified in writing of the Social Security Administration determination.

Limits on Extensions of the Maximum COBRA Coverage Period

In no case will the total maximum COBRA coverage period for anyone be more than 36 months, and in no case will the total COBRA coverage period for a participant be more than 18 months (29 months in the case of disability, as provided above). For a child born to, adopted by, or placed for adoption with a participant during continuation coverage, these periods are measured from the date of the event that triggered the continuation coverage in effect at the time of birth, adoption, or placement. In no event is the coverage period for such a child based on the date of birth, adoption, or placement.

All of the COBRA coverage periods described above are maximums. COBRA coverage can end before the end of these maximum coverage periods for several reasons, which are described in the following section. If a 36-month maximum COBRA coverage period applies, it cannot be extended under any circumstances.

Second Qualifying Event

For a participant’s spouse and dependent children, the maximum COBRA coverage period may be extended to a total of 36 months from the date of the participant’s termination or reduction in hours if, during the first 18 months (or 29 months, if a disability extension applies) that COBRA coverage is in effect, a second qualifying event occurs.

- A second qualifying event for a participant’s spouse may consist of the participant’s death, legal separation or divorce, but only if the event would have caused the spouse to lose coverage under the Plan had the first qualifying event not occurred.
- A second qualifying event for a participant’s dependent child may consist of the participant’s death, legal separation or divorce, or the dependent child’s ceasing to meet the dependent eligibility requirements under the Plan, but only if the event would have caused the dependent child to lose coverage under the Plan had the first qualifying event not occurred.
- For this extension to be available, written notice of the event must be properly given to the COBRA Administrator.

If notice is not provided to the COBRA Administrator within the applicable 60-day period, the extension of the maximum COBRA coverage period described in this paragraph will not be available as a result of that event.

Medicare Entitlement

Your COBRA coverage will terminate automatically if, after electing COBRA, you first become entitled to any Medicare benefits (Part A, Part B or both). You must notify the COBRA Administrator promptly after Medicare becomes effective. Regardless of whether this notice is provided, termination of COBRA coverage will be effective on the date of Medicare entitlement.

Cessation of Disability

Your COBRA coverage will terminate automatically if, after becoming entitled to a 29-month maximum coverage period due to your own or another qualified beneficiary’s disability, during the extension, there is a final Social Security Administration determination that the disabled individual ceased to be disabled. Within 30 days after receipt of the Social Security Administration determination, the COBRA Administrator must be notified in writing of that determination according to the notice procedures. Termination of COBRA coverage will be effective on the first day of the first month that is more than 30 days after the date of the Social Security Administration determination, regardless of whether you give the required notice.
Planning For the Future

**Special Rules On FMLA Leaves of Absence**

Loyola / Gottlieb is subject to the Family and Medical Leave Act of 1993 (FMLA), and, when allowing leaves protected under the FMLA, Loyola allows participants to continue group health plan coverage at regular contribution levels while on the leave. Beginning an FMLA leave is not an event which qualifies you for COBRA continuation coverage (beginning a non-FMLA leave may be a COBRA qualifying event, however). If one of the qualifying events listed earlier in this notice occurs during an FMLA leave, however, and, under the terms of the Plan, it normally would result in loss of coverage, then the normal rules described above concerning COBRA coverage would apply. In addition, if a participant who takes an FMLA leave does not return at the end of that leave, the last day of that leave may be treated as a reduction in hours for purposes of determining whether COBRA rights apply.

**Initial Payment for COBRA Coverage**

You are not required to send payment with your election of COBRA, but COBRA coverage under the Plan will not become effective until you have both properly elected coverage within the election period and paid your initial COBRA premium on time. Your initial COBRA premium is due no later than the 45th day after your election date. That initial payment must cover the premium for the period of COBRA coverage from the date on which Plan coverage would have ended if COBRA had not been elected through the last day of the month that ends before the due date for the initial payment.

**If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be directed to Loyola Human Resources. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Colleague Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Questions about your COBRA continuation coverage once you have elected it, including questions regarding premiums and coverage changes, should be directed to the COBRA Administrator.

**Keep the Plan Informed of Address Changes**

In order to protect your family’s rights, you should keep Loyola, and the COBRA Administrator (after electing COBRA continuation coverage), informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Loyola or the COBRA Administrator.

Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for that coverage. In most cases, the amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and colleague contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving COBRA coverage.

**Failure to Pay Required Premiums**

Your COBRA coverage will terminate automatically if the premium for your continuation coverage is not paid by the due date and any applicable grace period for paying the premium has expired without the past due premium being paid. Termination of COBRA coverage will be effective at the end of the last month for which the full premium was paid before expiration of the grace period for that payment.

**Plan Termination**

Your COBRA coverage will terminate automatically on the first date Loyola / Gottlieb ceases to provide any group health coverage to any colleague.
Colleague Discounts

◇ LASIK

LASIK at Loyola/Gottlieb

As an colleague of Loyola you are eligible for a discount for LASIK surgery. Please call or contact the Ophthalmology Department (708) 216-3833

◇ AAA

AAA Group & Voluntary Benefits Program

AAA Membership gives you discounted AAA Membership dues. As a member, you have 24-hour roadside assistance, access to a travel agency, a toll-free number. This membership also gives you access to AAA’s discounted auto and home insurance products. The benefit office has more information or look online at the LUMC benefit site or website

◇ Cell Phone

Cell Phone

Cell phone discounts are available through most carriers. For more information go to http://mybenefits.trinity-health.org/my-discounts.

◇ PACE

Access to Carpooling or VanPooling through PACE

As an added benefit to our colleagues, Human Resources has made it possible for those interested in carpooling/vanpooling to sign up with PACE Rideshare on line. In today’s economy, with the price of gas and parking, and the wear and tear on your car, many people have begun to explore other methods of getting to work.

www.PaceRideShare.com