Dear Associate & Family:

The Nemours “My Personal Choices” Benefits Guide is designed to provide you and your family with an overview of the benefits offered to Nemours Associates.

The Nemours Human Resources team works hard to maintain quality benefits that meet the needs of our Associates and their families. Offering a competitive benefits package helps Nemours attract the best talent and retain our valued Associates.

We are particularly proud of our continuing commitment to the Bridge to a Healthy Future, our pediatric health plan for the children of our full-time Associates. This unique plan provides comprehensive medical and prescription drug coverage for eligible children through age 19 with no payroll contributions and with low out-of-pocket costs.

Benefits enrollment is one of the most important tasks for new or newly eligible Associates. To get the benefits you want, you must enroll within your first 30 days of employment. If you miss this opportunity, you will have to wait until you experience a Qualified Event or the next Annual Enrollment. And for some benefits, not signing up when first eligible means that you may have to prove good health in order to get the coverage at a later date.

We encourage you to take advantage of the many benefit opportunities at Nemours. Take the time to carefully review the material in this guide and at www.nemoursbenefits.com so that you can make an informed decision about your benefits. If you have questions, please contact the Nemours HR Customer Service Center at 1-877-458-9699.

On behalf of the Nemours leadership team, I want to thank you for choosing Nemours and welcome any suggestions or feedback you may have on our benefits program.

Sincerely,

Terri Young
Vice President, Human Resources
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# General Disclaimer

The information in this guide is a summary of benefits only. If there is a discrepancy between the information provided in this guide and the Summary Plan Description (SPD), the SPD will govern.
My Personal Choices Benefits Program

My Personal Choices Benefits Program is Nemours’ comprehensive benefits plan for Associates and their families. It gives Associates the opportunity to choose benefits that meet their personal needs.

This guide provides summary information to assist Associates in making their benefit choices. This is not a contract; the complete terms and conditions are described in the plan booklets that are available online.

Enrollment
All new or newly eligible Nemours Associates have **30 days** from their date of hire or status change to enroll or waive their benefits online. Any full-time Associate who fails to enroll or waive within the 30-day enrollment period will be assigned the following benefits coverage: Medical and Dental—White Plan, individual coverage; Prescription Drug—Blue Plan, individual coverage; and Basic Life Insurance. Part-time Associates who do not enroll will have no benefits coverage. This assigned coverage will remain in effect until the next annual enrollment period or qualified event.

Effective Date
Your benefits begin the first of the month following or coinciding with your hire or status change date. For example, if your first day of employment is February 3, your benefits begin March 1. If your first day of employment is February 1, your benefits begin February 1. Your benefits remain in effect until December 31 of each year and you may not make a change mid-year unless you have a qualified event.

Eligibility
**Associates:** All full-time benefits-eligible Associates (working 30–40 hours a week) and all part-time benefits-eligible Associates (working 20–29 hours a week) who have satisfied the waiting period, are eligible to participate in the My Personal Choices Benefits Program.

**Spouse or Domestic Partner:** Your legal spouse, as defined by federal (not state) law, or your same-sex domestic partner who has a statement of Domestic Partnership on file with Nemours. Domestic partners must meet the following criteria:
- Must be the same gender
- Must have a Declaration of Domestic Partnership on file
- Must be in a committed relationship for at least six months
- Unrelated to Associate
- Age 18 or older
- Financially interdependent
- References to spouse will include domestic partners unless specifically excluded.

**Dependent Children:** Dependent children may be covered up to the age of 26, and beyond the age of 26 if disabled before age 26. A disabled child must be certified as disabled prior to the age of 26 AND must be primarily supported by the Associate.

The following children are eligible to be covered under the Nemours benefits plans, regardless of residence or financial dependency:
- An Associate’s biological or adopted child
- An Associate’s step-child (defined as the child of your legal spouse or your domestic partner for whom a Declaration of Domestic Partnership is on file)
- An Associate’s legal ward
- An Associate’s foster child (to age 18 only, letter of placement required)
- A child for whom an Associate has a Qualified Medical Support Order (QMSCO)

According to the above requirements, the following dependents would **NOT** be eligible for coverage under Nemours benefits plans:
- Opposite-sex domestic partner
- Common law spouse
- Divorced or legally-separated spouse
- Children who live in the Associate’s home and are financially dependent but who are not legal wards of the Associate (for example, grandchild)
- Children of opposite-sex domestic partners living in the Associate’s home and financially dependent who are not adopted or legal wards of the Associate

Dependent Verification
Any dependents added to the Nemours benefits plan—this includes spouses, domestic partners, and children—are subject to an eligibility verification process performed by Aon/Hewitt. Once your dependents have been enrolled, you will be asked to provide documentation (e.g., birth or marriage certificate, tax return) to verify their eligibility. If the required documentation is not provided within the time period specified, your dependents will be removed from the plan and you will not have the opportunity to enroll them again until the next annual enrollment period.

Status Changes and Qualified Events
If you experience a change in status, or a Qualified Event (such as the birth of a child or the loss of coverage from your spouse), you may be able to make changes to your benefits elections. This request must be submitted within **30 days** of the qualified event.

See page 23 of this guide for more information.
Medical

Nemours offers comprehensive medical coverage for Associates and their families. The medical plan is administered by BlueCross BlueShield of Delaware.

Nemours offers three levels of medical benefits: Red, Blue, and White. Contributions are made on a pre-tax basis. Plan types are described below.

<table>
<thead>
<tr>
<th>PLAN TYPE</th>
<th>RED</th>
<th>BLUE</th>
<th>WHITE</th>
<th>Bridge to a Healthy Future (FT Associate's Dependents Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PPO</td>
<td>EPO</td>
<td>PPO</td>
<td>PPO</td>
</tr>
</tbody>
</table>

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

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

**Eligibility**

All full-time and part-time Associates may elect or waive Red, Blue or White medical benefits. Eligible dependents may also be enrolled in the plans. Eligible dependents include your spouse and/or dependent children as defined below:

- **Dependent Children of Full-Time Associates**
  - May be enrolled in the **Bridge to a Healthy Future** plan (the Bridge Plan), regardless of the Associate’s Medical or Prescription Drug election until the end of the year in which they turn 19
  - May be enrolled with the Associate in the Red, Blue or White Dental plan and the Vision plan until the end of the month in which they turn 26
  - May be enrolled with the Associate in the Red, Blue or White Medical, Prescription Drug, Dental plan, and/or Vision plan between the ages of 19 and 26

- **Dependent Children of Part-Time Associates**
  - Are not eligible for the Bridge Plan
  - May be enrolled with the Associate in the Red, Blue or White Medical, Prescription Drug, Dental and/or Vision plans until the end of the month in which they turn 26

**ID Cards**

Medical and Prescription Drug ID cards will be mailed to your home. Associates electing dependent coverage will receive additional cards. Dependents enrolling in the Bridge Plan will receive their own ID cards with a unique identifier. ID cards are not re-issued every year, so please keep your card.

**Participating Providers**

The Nemours plan uses the national BlueCross BlueShield network, so no matter where you live or work, there are in-network providers near you.

Enter “NEM” in the provider search section of [www.bcbs.com](http://www.bcbs.com) to find participating physicians or facilities.

Please see the Medical Benefits Summary for a brief description of benefits offered through each plan.
## Adult Medical Benefits Summary

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>RED (PPO)</th>
<th>Out-of-Network¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Medical Deductible</td>
<td>$300 Individual/$600 Family</td>
<td>$600 Individual/$1,200 Family</td>
</tr>
<tr>
<td>Major Medical Coinsurance percent</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Major Medical Coinsurance Maximum (excluding deductibles)</td>
<td>$1,000 Individual/$2,000 Family</td>
<td>$3,000 Individual/$6,000 Family</td>
</tr>
<tr>
<td>Lifetime Benefit Maximum per Family Member</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>$20 co-pay</td>
<td>70%</td>
</tr>
<tr>
<td>Wellness/Routine Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Exams/Vision Exam</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Well-Child Care</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Diagnostic Mammograms</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Diagnostic X-Ray &amp; Lab Services Outpatient</td>
<td>X-ray 90%, Lab 90%</td>
<td>70%</td>
</tr>
<tr>
<td>Hospital Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Surgical Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Emergency Room (copay waived if admitted)</td>
<td>$100 co-pay</td>
<td>$100 co-pay</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$50 co-pay</td>
<td>$50 co-pay</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>$50 co-pay</td>
<td>$50 co-pay</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Outpatient (# Days covered: Same as any other illness)</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Chiropractic (30 days maximum per calendar year)</td>
<td>100% after $20 co-pay</td>
<td>70%</td>
</tr>
<tr>
<td>Short Term Rehab: Physical, Speech, Occupational, Cardiac, or Cognitive Therapy</td>
<td>$20 co-pay</td>
<td>70%</td>
</tr>
</tbody>
</table>

Note: Deductible and Out-of-Pocket maximums apply to all benefits covered with coinsurance. The above summaries apply to all covered dependent children of part-time Associates and the children of full-time Associates who are over the age of 19. This chart summarizes amounts paid by the plan. If there is a discrepancy between the information here and the plan document, the plan document governs. This chart does not describe all plan exclusions and limitations.

¹All out-of-network benefits are subject to balance billing.
<table>
<thead>
<tr>
<th>BLUE (EPO)</th>
<th>WHITE (PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network ONLY (EPO)</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>$600 Individual/$1,200 Family</td>
<td>$1,200 Individual/$2,400 Family</td>
</tr>
<tr>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>$2,000 Individual/$4,000 Family</td>
<td>$3,000 Individual/$6,000 Family</td>
</tr>
<tr>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>$30 co-pay</td>
<td>$40 co-pay</td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>X-ray 80%, Lab 80%</td>
<td>X-ray 70%, Lab 70%</td>
</tr>
<tr>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>$100 co-pay</td>
<td>$100 co-pay</td>
</tr>
<tr>
<td>$50 co-pay</td>
<td>$50 co-pay</td>
</tr>
<tr>
<td>$50 co-pay</td>
<td>$50 co-pay</td>
</tr>
<tr>
<td>100% after $30 co-pay</td>
<td>100% after $40 co-pay</td>
</tr>
<tr>
<td>$30</td>
<td>$40 co-pay</td>
</tr>
</tbody>
</table>
**Bridge to a Healthy Future Benefits Summary**

Full-time benefits eligible Associates may elect prescription and medical (PPO) coverage for their eligible dependent children, at no additional cost. Nemours will pay 100 percent of the premium for this plan. The Bridge Plan does have exclusions and limitations. If you use an out-of-network provider, you will be responsible for balance billing in addition to applicable deductibles and coinsurance.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Out-of-Network^2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td>$100</td>
</tr>
<tr>
<td><strong>Coinsurance Percent</strong></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td><strong>Coinsurance Maximum (excluding deductibles)</strong></td>
<td></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Lifetime Benefit Maximum</strong></td>
<td>$100</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits, PCP/Specialist</td>
<td>$10 co-pay</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Allergy Testing/treatment</td>
<td>$10 co-pay</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Gynecological Exam</td>
<td>Covered at 100%</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>Covered at 100%</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Routine Health Exam/Vision Exam</td>
<td>Covered at 100%</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Surgery/Anesthesia (inpatient)</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Outpatient (non-Emergency Room)</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>Diagnostic X-Ray/Lab Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>$50 co-pay</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Outpatient (# Days covered: Same as any other illness)</td>
<td>Deductible &amp; Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>Short Term Rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy (maximum of 50 visits per calendar year)</td>
<td>$10 co-pay</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Physical Therapy (maximum of 50 visits per calendar year)</td>
<td>$10 co-pay</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Speech Therapy (maximum of 50 visits per calendar year)</td>
<td>$10 co-pay</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>$10 co-pay</td>
<td>Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>$0/$15/$30*</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

This chart is only a summary of the more common benefits of your plan. This chart summarizes amounts paid by the plan, benefit maximums and additional explanations of your benefits. If there is a discrepancy between the information here and the plan document, the plan document governs. This chart does not describe other plan exclusions and limitations. ^2 All out-of-network benefits are subject to balance billing.

Prescription Drug benefit is subject to some exclusions and limitations; review Rx Plan summary for details. All programs listed on the following pages, starting with the Generics Preferred Program, also apply to the Bridge Plan.
Nemours offers a separate prescription drug plan through Express Scripts. There are two levels of prescription drug coverage: Red and Blue. Contributions are taken on a pre-tax basis.

**Eligibility**
Associates: All full-time and part-time Associates may elect or waive the Red or Blue Prescription Drug plan completely independently of the Medical Plan. Eligible dependents may also be enrolled in your plan. You may:
- Elect prescription drug coverage even if you waived medical coverage
- Elect a prescription drug plan that does not match your medical election
  - i.e., Red Medical and Blue Prescription Drug
  - i.e., Associate + Spouse Medical and Associate-Only Prescription Drug

**Exception**
Prescription Drug coverage for dependents (eligible as defined under the Medical Benefits description) enrolled in the Bridge Plan is included along with medical.

**ID Cards**
ID Cards will be mailed to your home. Two ID cards per Associate will be issued. Dependents enrolled in the Bridge Plan will receive their own ID card with a unique identifier. Additional ID cards are available upon request.

**How to Use the Program**
The following drug information and programs apply to both the Adult and *Bridge to a Healthy Future* Prescription Drug plans.

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

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

**Definitions**
**Generic**
There is no co-pay for generic drugs. Generic drugs have been approved by the U.S. Food and Drug Administration (FDA) for quality and safety, and are absorbed into the bloodstream in the same way as a brand name drug.

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

**Preferred Brand**
Associates will pay higher co-pays for preferred brand name drugs which are drugs still protected by patents (meaning no chemically equivalent generic equivalent is available). The U.S. Food & Drug Administration (FDA) has approved these higher-cost drugs after trials show they are safe and effective. When a generic drug is introduced for a preferred brand name drug, the brand name will automatically move from Preferred Brand to Non-Preferred Brand. Check our carrier links regularly for updates.
**Non-Preferred Brand**
Associates will pay the highest co-pay for non-preferred brand name drugs (which are listed in this tier for a variety of reasons). These drugs may have been excluded because there are other, lower-cost brand name drug(s) that are just as effective.

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

**Mail Order Program**
These drugs are ongoing, long term prescriptions (for conditions such as high blood pressure, diabetes and heart conditions). For two co-pays, you may purchase a 90-day supply of maintenance medication through the mail order program. These co-pays are based on the tier structure below. Your physician must write the prescription for a 90-day supply. For more information regarding Express Scripts mail order drug program, please contact Express Scripts directly, via their web site or toll-free number listed at the end of this guide.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Red Co-pay</th>
<th>Blue Co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$15</td>
<td>$30</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$40</td>
<td>$60</td>
</tr>
<tr>
<td>Mail Order</td>
<td>2x Retail Co-pay</td>
<td>2x Retail Co-pay</td>
</tr>
</tbody>
</table>

**CuraScript Exclusive Program**
Specialty medications (usually high cost or injectable drugs) must be filled through CuraScript, a leading specialty pharmacy. Through the CuraScript program, you will have access to:

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

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

**Nemours/Alfred I duPont Hospital for Children (N/AIDHC) Outpatient Pharmacy**
Associates in the Delaware Valley who are covered under the Nemours prescription drug plan may fill prescriptions for both dependent children AND many adult prescriptions at the N/AIDHC outpatient pharmacy. The hospital pharmacy offers a three-month supply of maintenance medications (except for specialty drugs) for two copays, just like the Express Scripts mail order program.
Voluntary Vision

Nemours offers a voluntary Vision Program through VSP (Vision Service Providers) on a pre-tax basis. The Vision plan is a PPO Plan, and offers you the freedom to seek care from any provider that you wish. If you use an in-network (participating) provider, you will generally pay a co-pay. If you utilize an out-of-network doctor, you may be reimbursed up to the amounts shown in the chart below. All services are covered once per 12 months except for frames, which are covered once every 24 months.

<table>
<thead>
<tr>
<th>Benefits In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam $15 co-pay</td>
<td>Reimbursed up to $34.00</td>
</tr>
<tr>
<td>Single Vision Lenses $25 co-pay</td>
<td>Reimbursed up to $17.00</td>
</tr>
<tr>
<td>Bi-focal Lenses $25 co-pay</td>
<td>Reimbursed up to $30.00</td>
</tr>
<tr>
<td>Tri-focal Lenses $25 co-pay</td>
<td>Reimbursed up to $43.00</td>
</tr>
<tr>
<td>Lenticular Lenses $25 co-pay</td>
<td>Reimbursed up to $100.00</td>
</tr>
<tr>
<td>Frame Covered up to $130.00 allowance, 20% discount off balance</td>
<td>Reimbursed up to $38.25</td>
</tr>
<tr>
<td>Contact Lens Services (Fitting &amp; Evaluation) and Contact Lenses: Elective Covered up to $130.00</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Necessary Reimbursed up to $100.00</td>
<td>Reimbursed up to $210.00</td>
</tr>
</tbody>
</table>

To Utilize Your VSP Benefits:
1. Consult your Vision Plan booklet for coverage details
2. Find a VSP doctor online or by phone 24 hours a day
3. Make an appointment with a VSP doctor and identify yourself as a VSP member

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

NOTE: Our Medical Insurance plan also includes a Vision Discount Program, and covers one eye exam every two calendar years. Your Medical and VSP Vision discounts cannot be combined.

Dental

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

Passive PPO Network

A passive PPO allows you to choose any dentist. Although the reimbursement percentages are the same for in- or out-of-network coverage, you will save on out-of-pocket expenses by receiving services from an in-network dentist. You can go online to find an in-network provider in your area; please use the contact information at the end of the guide. Definitions of “Reasonable & Customary” and “Maximum Allowable Charge” are available in the Appendix section of the Benefits Guide.

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>RED - Reasonable &amp; Customary Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>Preventive</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Restorative</td>
<td>80%</td>
</tr>
<tr>
<td>Major Restorative</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>50%</td>
</tr>
<tr>
<td>Deductible**</td>
<td>$50</td>
</tr>
<tr>
<td>Individual</td>
<td>$150</td>
</tr>
<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Annual Maximum Per Person</td>
<td>$2,000</td>
</tr>
<tr>
<td>Orthodontia Lifetime Maximum Per Person</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

*All Out-of-Network benefits are subject to balance billing based on Reasonable and Customary Charges  **Applies only to Basic and Major Restorative Services
The following procedures have limitations on the frequency with which the procedures can be performed, as follows:

### Procedure Frequency Schedule

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

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

Nemours offers a Basic Term Life and Accidental Death and Dismemberment (AD&D) benefit of one times your base annual salary to a maximum of $250,000. Term Life insurance does not accrue a cash value and terminates when you leave employment. This benefit is employer paid for all full-time Associates. Regular part-time Associates may elect this benefit and pay 100 percent of the premium.

### Voluntary Term Life

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

Associates may purchase Voluntary Term Life insurance in increments of $10,000 up to the lesser of $750,000 or four times your base annual salary. Guarantee Issue coverage is available for newly eligible Associates in the amount of $500,000. Amounts over the Guarantee Issue for newly eligible Associates are subject to Evidence of Insurability (E of I). All elections for late enrollees are subject to E of I. At Annual Enrollment, Associates currently enrolled in the plan may increase their election by one level ($10,000) without E of I, up to the Guaranteed Issue amount of $500,000. Any amounts elected over the Guarantee Issue level will be subject to E of I.
Associates may purchase Term Life insurance for their spouse in increments of $10,000 to a maximum of $380,000. Guarantee Issue coverage is available for newly eligible spouses in the amount of $100,000. Any increases or amounts over $100,000 will be subject to E of I. All elections are subject to E of I for late enrollees.

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

**Voluntary Accidental Death & Dismemberment (AD&D)**

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

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

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

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

**Voluntary Universal Life**

Nemours allows Associates to elect Universal Life through convenient post-tax payroll deductions. Universal Life combines the protection of life insurance with the ability to grow cash value on a tax-deferred basis. Universal Life is portable at the same rates.

Newly eligible Associates may purchase up to $150,000 of conditional guaranteed issue coverage. Conditional Guaranteed Issue means that you have to answer only a few questions in order to be approved for the Conditional Guaranteed Amount. Coverage for late enrollees will be subject to medical underwriting. Associates may purchase coverage for themselves and/or their eligible dependents, as follows:

<table>
<thead>
<tr>
<th>Dependent Tiers</th>
<th>Benefit Maximum</th>
<th>Monthly Contribution Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Options - Costs will vary based on age &amp; smoker status</td>
<td>$150,000</td>
<td>$17.34–$108.34</td>
</tr>
<tr>
<td>Spouse Options - Costs will vary based on age &amp; smoker status</td>
<td>$50,000</td>
<td>$17.34–$30.34</td>
</tr>
<tr>
<td>Child Option</td>
<td>$25,000</td>
<td>May be stand alone, $6.50 per child</td>
</tr>
</tbody>
</table>

**Voluntary Critical Illness**

Nemours offers Critical Illness coverage through convenient post-tax payroll deductions for Associates, spouses and dependents. Critical Illness coverage provides you with a lump sum payment in the event that the covered individual experiences one of the following: Cancer, Heart Attack, Stroke, Renal Failure or Major Organ Transplant. Benefits may be elected in increments of $5,000 and a maximum of $100,000. Critical Illness Insurance is portable.

This coverage pays cash benefits directly to Associates diagnosed with any of the covered conditions. This insurance pays in addition to the health insurance coverage provided to Associates, and is designed to help you offset the deductibles, co-pays and indirect costs associated with a serious illness. An annual Critical Illness wellness screening benefit of $50 is payable to Associates and covered persons for such early detection tests such as mammogram, pap smear, PSA and several others.

**Voluntary Long Term Care**

Nemours offers Long Term Care (LTC) coverage through the convenience of post-tax payroll deductions for both Associates and their spouses. Additionally, parents, grandparents, in-laws and grand in-laws are also eligible for participation through this plan; UNUM bills premiums directly to the covered subscriber. Coverage for Long Term Care insurance is fully portable. Coverage is not available to domestic partners.
Long Term Care (LTC) coverage provides an allowance for custodial assistance to individuals who are unable to perform two of six Activities of Daily Living (ADL) due to a disability. Activities of Daily Living include bathing, dressing, eating, toileting (grooming), continence (using the bathroom without help) and transferring (moving from the bed to a chair, or vice versa). LTC is also payable if the subscriber has a cognitive impairment.

Custodial assistance may be provided by any of the following: a Skilled Nursing Facility, a Home Health Care Agency (called Professional Home Care), an Assisted Living Facility, or a member of the community (Total Home Care, including your family members).

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

<table>
<thead>
<tr>
<th>Provision Options</th>
<th>3 Year Benefit Duration</th>
<th>6 Year Benefit Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Facility Benefit Amount Options</td>
<td>$1,000 to $4,000</td>
<td>$1,000 to $4,000</td>
</tr>
<tr>
<td>Skilled Nursing Facility*</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Assisted Living Facility*</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Total/Professional Home Care</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Lifetime Maximum**</td>
<td>Monthly Facility Benefit Amount (multiplied by 36)</td>
<td>Monthly Facility Benefit Amount (multiplied by 72)</td>
</tr>
</tbody>
</table>

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

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

**Voluntary Short Term Disability**

Nemours offers Short Term Disability insurance to Associates through Mutual of Omaha. Contributions are taken on a post-tax basis.

Short Term Disability insurance offers income protection for disabilities caused by illness, accident or injury that are NOT work-related. Maternity is covered as any other illness. All claims are subject to carrier approval. There are two plans offered:

<table>
<thead>
<tr>
<th>Provisions</th>
<th>STD Plan 1</th>
<th>STD Plan 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination Period</td>
<td>14 days for accident or illness</td>
<td>7 days for accident or illness</td>
</tr>
<tr>
<td>Benefit Duration</td>
<td>Maximum of 13 weeks</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td>40%, 50%, or 60% of your weekly earnings to a maximum of $1,000</td>
<td></td>
</tr>
</tbody>
</table>

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

**Voluntary Long Term Disability**

Nemours offers Long Term Disability insurance to Associates through Mutual of Omaha. Contributions are taken on a post-tax basis.

Long Term Disability insurance offers income protection for disabilities caused by illness, accident or injury. All benefits are subject to carrier approval. There are two plans offered. Note that Plan 2 is available only to Associates earning over $70,000 annually.

Newly eligible Associates may elect Long Term Disability without providing Evidence of Insurability (E of I). At Annual Enrollment, Associates currently enrolled in the plans may increase or decrease coverage or change plans. Late enrollees may apply, but elections are subject to review and approval of E of I.
All Long Term Disability plans include a pre-existing condition limitation. Newly elected plans or plan changes will be subject to a pre-existing condition limitation.

<table>
<thead>
<tr>
<th>Provisions</th>
<th>LTD Plan 1</th>
<th>LTD Plan 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>All Benefits Eligible Associates</td>
<td>Associates earning over $70,000 annually</td>
</tr>
<tr>
<td>Elimination Period</td>
<td>90 Days</td>
<td></td>
</tr>
<tr>
<td>Benefit Duration</td>
<td>Up to Social Security Normal Retirement Age.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you become disabled after this age, there is a reduced benefit duration.</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td>40%, 50%, or 60% of your monthly earnings to a maximum of $10,000</td>
<td>60% of your monthly earnings to a maximum of $10,000</td>
</tr>
<tr>
<td>Own Occupation Duration</td>
<td>Two Year Own Occupation</td>
<td>Own Occupation to Social Security Normal Retirement Age</td>
</tr>
</tbody>
</table>

**Flexible Spending Accounts (FSAs)**

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

- **Health Care Spending Account**: Covers charges not covered or partially covered by health, dental, prescription drug, and vision programs such as co-pays and deductibles for you and your eligible dependents.

- **Dependent Care Spending Account**: Covers charges for day care or similar care to eligible dependents as defined by the IRS. A list of provider requirements is available on the HFS Benefits web site.

- **Mass Transit Spending Account**: Covers charges for public transportation related to the commute to and from work.

- **Parking Spending Account**: Covers charges for public parking related to the commute to and from work.

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

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

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

**Tax Effect**

Contributions to FSAs reduce the amount of taxable income. This results in savings of FICM, FICA, federal and state income taxes.
Health Care Flexible Spending Account

Health Care Flexible Spending Accounts help pay for expenses that are either partially covered or not covered by Medical, Prescription Drug, Dental or Vision insurance. You may contribute up to $4,000 in the account each plan year. You may participate in this account even if you have not enrolled in a Medical, Dental or Prescription Drug plan.

Examples of Health Care Expenses Not Covered by Insurance

- Deductibles
- Co-payments
- Certain over-the-counter items such as saline or first aid supplies

For extensive details on qualified expenses, visit www.hfsbenefits.com. In general, you may use a Health Care Flexible Spending Account to pay most health expenses that qualify as a medical deduction for federal income tax purposes (as described in the IRS Publication 502) for yourself or your tax dependents. Health care expenses reimbursed through the FSA account cannot be claimed as deductions for federal income tax purposes.

Grace Period: Nemours has elected to allow an additional 2.5 months extension of the Health Care Spending Account only (this extension is not available on the Dependent Care Spending Account). This means that you may use your prior plan year account balance until March 15 of the next plan year. If you use your debit card, your card will automatically pull funds from your prior plan year balance if available, and then from your current year’s balance.

Additional Claim Information

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

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

Worksheet to Calculate Health Care Contributions

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

<table>
<thead>
<tr>
<th>Health Care Expenses Worksheet</th>
<th>Estimated Costs:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td></td>
</tr>
<tr>
<td>Note, if you usually do not meet the deductible, include only the amount you anticipate incurring.</td>
<td></td>
</tr>
<tr>
<td><strong>Co-payments</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dental</strong> co-pays or costs not covered under the dental plan</td>
<td></td>
</tr>
<tr>
<td><strong>Vision</strong> exams, glasses or contact lenses, if not covered or only partially covered under insurance</td>
<td></td>
</tr>
<tr>
<td><strong>Medical</strong> portion of routine physical exams not covered under insurance</td>
<td></td>
</tr>
<tr>
<td>Other allowable medical expense</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

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

Dependent Care Flexible Spending Accounts allow you to set aside pre-tax dollars to provide care for your eligible dependents, so you (and your spouse) can work.

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

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

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

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

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

Please note: If your spouse is a full-time student at least five months a year, or disabled, federal law limits the maximum pre-tax amount you may contribute. Contributions from highly compensated individuals may also be limited or amended as a result of federally required non-discrimination testing. Please contact your Human Resources Customer Service Center for details.

**Worksheet to Calculate Dependent Care Contributions**

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

**Dependent Care Expenses Worksheet**

<table>
<thead>
<tr>
<th>Estimated Costs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ _______________</td>
</tr>
<tr>
<td>$ _______________</td>
</tr>
<tr>
<td>$ _______________</td>
</tr>
<tr>
<td>$ _______________</td>
</tr>
</tbody>
</table>

- Wages or Salary Paid to Caregiver
- FICA and other taxes you pay on behalf of caregiver, if applicable
- Payment to a licensed dependent care facility
- Eligible expenses for care before and/or after your child goes to school
- Eligible expenses for a housekeeper who provides care for a qualified dependent
- Total

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

Transportation Flexible Spending accounts allow you to set aside pre-tax dollars to cover mass transit or parking expenses related to your commute to and from work. There are two types of accounts, mass transit and parking. You may elect to participate in one or both of these accounts. The maximum monthly election for the mass transit account is $125 and for the parking account, $240.

Mass Transit Accounts

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

- Trains
- Subways
- Trolleys
- Buses

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

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

Accessing your Mass Transit Account funds:
Per IRS regulations, the debit card is the only method to access your available mass transit funds.

Your debit card will be accepted only at merchants coded as a mass transit facility in the MasterCard transaction system such as a SEPTA or NJ Transit station. A convenience store that sells bus passes would NOT be recognized.

Parking Account

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

Accessing your Parking Account funds:
You may access your Parking account funds in two ways:

1. Use your Debit card at a parking facility

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

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

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

**Once you’ve enrolled, be on the lookout for your card.**

A debit card will be mailed to your home in a plain white envelope. Please read the cardholder agreement that is included with the card. Additional or replacement cards may be purchased at $5.00 each by completing the form that is found under Important Forms and Documents on www.nemoursbenefits.com.

**Activation is easy...**

To activate your card, all you need to do is purchase an item at a location where the card can be physically swiped (not keyed in). An initial order either by mail or online will not activate the card.

**Where can I use the card?**

You may use your debit card at the following locations

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

If you use your card at an unqualified merchant, the transaction will be declined. For a listing of merchants that have an IIAS system installed, please go to www.hfsbenefits.com.

**It is called a debit card, but use it like a credit card.**

At the merchant’s point-of-service keypad, choose “credit” because no PIN is assigned to the card. The card is called a debit card because you may use it for expenses, up to your annual Health Care FSA election (or available balance), or your withholdings to-date (or available balance) for the Dependent Care FSA. Any transactions over your account balance will be declined.

**What debit card transactions must be substantiated?**

After you use your debit card, you must send documentation to HFS in the following situations:

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

**How do I substantiate a debit card transaction?**

You need to complete a debit card substantiation form (available at www.nemoursbenefits.com), attach a valid receipt and send it to HFS. A valid receipt must include the vendor’s name, a description of the purchase, the amount of the purchase and the purchase date.

**What happens if I do not submit documentation for my debit card transaction?**

If you do not provide the required documentation as requested, your debit card will be deactivated and you may be asked to reimburse the plan for the unsubstantiated amount.

**How long can you use your card?**

Your card does not expire for three years and one month from your effective date. A card with an expiration date of “1/11” does not expire until January 31, 2011. If you are enrolled in an account for the plan year in which your card is scheduled to expire, you will automatically receive a new card prior to the card expiration date.
Other FSA Information

Please remember you can access your Flexible Spending Account (FSA) through the internet. You may view detailed information such as your account balance, claim status and payment information. This information will be available to you 24 hours a day, seven days a week. If you have any questions regarding your account, please call your HFS representative at 410-771-1331 or 888-460-8005.

To Access Your Account, Follow the Simple Steps Below

• Go to www.hfshbenefits.com
• Click on “Participant Login”
• Click on “Register (create an account)”
• Enter the following information: Social Security Number, Last Name, Zip Code, and E-mail Address
• You will be prompted to enter your date of birth or debit card number and select a new username and password.

Once created, click “Create User”

The following options are available to you:

Claims: The claims button will allow you to view all claims submitted for your account
Payments: View payments made out of your FSA account
Balances: View YTD information for your account(s)

Pre-Paid Legal Plan

Nemours offers a popular pre-paid legal plan through MetLaw®. Contributions are taken post-tax. The MetLaw® plan is a simple, affordable way to access the most frequently needed personal legal services such as wills, powers of attorney and identity theft defense. Some of the covered services include:

• Family and personal law such as adoption, guardianship and garnishment defense
• Money matters such as identity theft defense, debt collection defense and personal bankruptcy
• Vehicle and driving law such as driving privileges restoration and license suspension
• Home and real estate law such as foreclosure, eviction defense and title disputes
• Civil lawsuits such as small claims assistance and disputes over consumer goods
• Estate law such as simple wills, powers of attorney and healthcare proxies
• Elder care law related to your parents

MetLaw® is offered by Hyatt Legal Plans and gives participants access to a network of more than 11,000 attorneys. Attorneys in the network meet stringent criteria and are regularly reviewed to ensure they continue to meet plan standards. Both in-network and out-of-network benefits are available.

Health Advocate

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

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

• Find the right doctors within your plan’s network
• Schedule appointments with hard-to-reach specialists
• Resolve insurance claims and untangle medical bills
• Obtain prior authorizations and assist with appeals
• Estimate the cost of health care services
• Understand tests, treatments and medications
• Locate eldercare and support services
• Facilitate the transfer of medical records
• Find the newest medical treatments available
Employee Assistance Program (EAP)

The Nemours Employee Assistance Program (EAP) services are provided to all benefits eligible Associates, and their household dependents. The Nemours EAP provides short-term counseling for problems that may be affecting work performance or other important areas of life. Examples include: relationship struggles, substance abuse concerns, or feelings of anxiety or depression. For long-term counseling, financial or legal problems, Nemours EAP representatives will provide the appropriate referrals.

The first four “situational” visits are provided at no out-of-pocket cost to eligible Associates. Any sessions beyond the first four “situational-based” concerns are the responsibility of the Associate; and must be arranged separately from the Nemours EAP service. Your counselor can assist you in accessing your health insurance benefit for counseling. Counseling is provided through Nemours EAP and the Delaware Family Center. To take advantage of this benefit, simply call 1-888-NEMOURS (1-888-636-6877). The intake representative at the Delaware Family Center will gather relevant information and arrange for a counselor to contact you.

Wellness Program

The Nemours wellness program is an investment in Associates’ health, both now and for the future. Our focus is on increasing Associate awareness and encouraging positive behavior changes through ongoing education and activities. Participation is voluntary and offered at no cost to the Associate. Some of the activities and programs included are:

- **Health Risk Assessment (HRA)**— an online tool to help you understand how your behaviors and lifestyle may impact your health
- **Lifestyle Coaching**—the opportunity to work one-on-one with a coach to overcome obstacles to better health
- **Educational Programs**—both online and onsite programs on health-related topics such as stress management, healthy eating, smoking cessation, exercise and weight management

Medical Information Helpline

The Medical Information helpline is a personal health management system that provides Nemours benefits eligible Associates a variety of options for obtaining expert health information. This benefit is provided to you and your covered dependents at no cost and is available 24 hours a day, seven days a week, 365 days a year. Whether you want to know if you should take your child to the emergency room now or if you should wait and call the doctor in the morning, or you are simply looking for health information, you can call and have a registered nurse assist you, answer your questions, or mail you helpful information. Your privacy is protected. All calls and online chats are confidential and protected by the Health Insurance Portability & Accountability Act (HIPAA).

The nurses are trained to engage and support members and to provide health information and decision support based on nationally recognized clinical guidelines and HIPAA compliance. They do not engage in clinical diagnosis. Use of the Medical Information Helpline supports health care decision-making at your time of need by helping you understand safe and appropriate care settings and potential medical treatment options.

Tuition Reimbursement

All benefits eligible Associates are eligible to participate in the tuition reimbursement program, after the completion of the 90-day evaluation period, provided the course is approved prior to enrollment. Courses available for reimbursement must be related to the work you are performing. Reimbursement is based upon the grade earned (minimum Grade “C” or “pass”), and is limited to $5,250 per year.

Repayment is required if you terminate or have a change in status within one year of payment of reimbursement. For additional details regarding this program, please contact the Human Resources Customer Service Center at 1-877-458-9699.
**Retirement Plan**

All Associates hired or rehired on or after January 1, 2010 will automatically be enrolled in the 403(b) Retirement Savings Plan at a four percent (4%) of salary contribution level. Tax-deferred contributions will begin approximately 30 days after your hire date. Associates may increase or stop their contributions at any time. To opt out of the automatic contribution, Associates should contact Diversified Investment Advisors as soon as possible.

Associates who have a full-time equivalency (FTE) of at least .4807 will receive a fifty percent (50%) matching contribution each paycheck from Nemours, up to a maximum of two percent (2%) of salary. Associates are immediately vested in the employer matching contribution.

At the completion of each calendar quarter, Associates with an FTE of at least .4807 who have been paid for at least 250 hours in the quarter, will also receive a basic 403(b) contribution from Nemours. The basic contribution is based on the compensation paid in the quarter and is vested after the completion of three (3) years of vesting service (years of 1,000 or more hours). The schedule for the basic contribution is shown below:

<table>
<thead>
<tr>
<th>Years of Nemours Service</th>
<th>Employer Basic Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4 Years</td>
<td>3%</td>
</tr>
<tr>
<td>5–9 Years</td>
<td>4%</td>
</tr>
<tr>
<td>10–14 Years</td>
<td>5%</td>
</tr>
<tr>
<td>15–19 Years</td>
<td>6%</td>
</tr>
<tr>
<td>20–24 Years</td>
<td>7%</td>
</tr>
<tr>
<td>25+ Years</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Roth Contributions**

Associates may also elect to make Roth contributions to the 403(b) Retirement Savings Plan. All contributions to the 403(b), regardless of type, are subject to applicable IRS annual limits. These are personal limits, so any 401(k) or 403(b) contributions made with another employer count towards the IRS limits.

For complete details about the Nemours 403(b) Retirement Savings Plan, please contact Diversified Investment Advisors at 1-888-676-5512.
May I make an election at any time other than when first eligible or at Annual Enrollment?
In some circumstances, you may make a mid-year change. These circumstances are governed, in part, by the IRS, and are called “Qualified Events.” Examples of Qualified Events include marriage, divorce, birth of a child, loss of coverage and some other specific events. These events allow you to make a “Mid-Year Change.” You may find a detailed listing of allowed Mid-Year Changes online.

Is there a time limit to make a mid-year change?
Yes. You have 30 days from the event to submit a request for a mid-year change.

How do I request a mid-year change?
Request your change by completing a Benefit Enrollment Change Form. You must submit documentation with your form before the change will be processed.

What happens to my benefits if I terminate employment with Nemours?
Your benefits options vary depending on what you had in force prior to your termination. Different benefits have different continuation options. For example, Medical, Dental, Prescription Drug, Vision, Employee Assistance Program and Healthcare Flexible Spending Accounts may be continued for specified periods of time through COBRA. Term Life insurance may be ported or converted, and Universal Life & Long Term Care may be taken with you at exactly the same rates that you currently pay. There are limits to the amount of time that you have to make elections to continue terminated coverage. You may find a detailed listing of benefits available upon termination (and information about those benefits) online, in the Termination Chart.

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

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

Annual Enrollment
A period of time when people may enroll in health insurance and other benefit plans. Many annual enrollment periods allow people to enroll regardless of the state of their health.

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

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

Coordination of Benefits (Birthday Rule)
If both spouses are working and carry dependent coverage, the responsibility for primary coverage falls to the parent having the earlier birthday in the calendar year, regardless of which parent is older. Coordination of Benefits applies to the Bridge to a Healthy Future plan, and all Adult Medical and Dental plans. (Does not apply to Prescription Drug plans.)

Co-payment
A specified flat fee an individual pays for health care services or prescriptions. For example, the patient may pay a $20 co-payment for each doctor visit, or $15 for each prescription.

Deductible
The amount an individual must pay for services before a health care plan begins to pay benefits. Most plans have a maximum family deductible that is satisfied by the combined expenses of all covered family members, generally two to three times the individual amount.

Dependent
Additional members of an Associate’s household that are eligible to be covered by the group’s policy. Generally these are a spouse and children who live at home.

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

Eligibility
Conditions to be met in order to receive a benefit or participate in a group benefit plan. Eligibility varies by plan. For Associates, it is generally based on employment status (i.e. non-benefits-eligible to benefits-eligible). Eligibility for dependents is based on the benefit, age and relationship to the Associate.
Elimination period
The amount of time before the benefit payment will begin. Elimination periods typically refer to disability.

Emergency
An Emergency is defined as:
• A condition serious enough to cause a prudent person to seek emergency care
• A situation where a delay in care might cause permanent damage to your health
• A situation where you have care within 48 hours from the onset of the condition

Please note that if you use the emergency room and it is not considered an emergency, and you have not received a referral from the Medical Information Helpline, the claim will not be covered, and you will be responsible for all charges.

Evidence of Insurability (E of I)
A statement or proof of a person’s physical condition, occupation or other factor affecting his or her acceptance for insurance. Usually not required for enrollment in group health plans, and prohibited for COBRA continuation coverage; however, may be required for disability, life or accident insurance over certain levels or for late enrollment.

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

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

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

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

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

Life Status Change (Qualified Status Change / Family Status Change)
The only time, other than Annual Enrollment, when an Associate may change Medical, Dental, Prescription, Drug, Vision, Flexible Spending, or other benefits coverage. Qualifying events include (but are not limited to) marriage or divorce, birth or adoption of a child, death of a spouse or dependent, gain or loss of employee or spouse’s employment, or a change in job status that affects benefits coverage. Changes in coverage must be made within 30 days of the date of the qualifying event. (See page 30 for additional information.)

Lifetime Maximum
The total amount a health insurance policy will pay over the course of an individual’s lifetime.
**Maximum Allowable Charge (MAC)**
MAC is a method of reimbursement for charges. MAC is the discounted amount that is paid to an in-network provider for services rendered. A MAC plan pays an out-of-network provider at the same level as an in-network provider. All amounts above the MAC are the responsibility of the Associate.

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

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

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

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

**Out-of-Pocket Maximum**
An annual limit on how much money an individual must pay (deductible, co-payments, and coinsurance) before the health plan begins to pay 100 percent of their health care expenses. Some plans have a family out-of-pocket limit that is satisfied by the combined expenses of all covered family members, generally two to three times the individual amount.

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

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

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

**Pre-Tax Contribution**
Contributions that are deducted from an Associate’s paycheck before federal, most state and local, and Social Security taxes are figured, reducing taxable income.
Primary Coverage
The health coverage most responsible for paying your claims if you have duplicate coverage.

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

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

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

Reasonable & Customary Charges (R&C)
The lowest of the usual charge of most other dentists or other providers in the same geographic area for the same or similar services or supplies OR the usual fee that the individual dentist most frequently charges the majority of his or her patients for a service or supply OR the actual charge for the services or supplies.

Spouse
Legally married spouses or same-sex domestic partners of Associates are eligible to participate in My Personal Choices Benefits Program, except Long Term Care. Domestic partner eligibility must be certified. See Human Resources pages on Nemours intranet for information and forms. Any reference to “Spouse” includes same-sex domestic partners.

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

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

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

Waive
To intentionally decline coverage in a benefits plan; some plans require proof of coverage elsewhere.
Frequently Asked Questions (FAQ)

Flexible Spending Accounts

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

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

To what age may I use the Dependent Care FSA for daycare expenses incurred for my child?
You may submit expenses incurred for your dependent child before his/her 13th birthday, or longer if disabled.

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

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

What is the schedule for reimbursement of submitted expenses?
If the receipt of the paid transaction and reimbursement request is received by HFS by noon on Wednesday, the payment will be released via check in the mail or released for direct deposit in an electronic funds transfer on the following Tuesday.

IMPORTANT NOTE FOR DIRECT DEPOSIT: Although payment is released on Tuesday from HFS via direct deposit in an Associate’s bank account, each individual bank has its own rules as to when it processes the direct deposit payments it receives. Associates should consult with their bank for details.

Medical

Where can I find a list of available doctors/hospitals?
Go to www.bcbs.com and click the link to “find a provider” located on the right hand side of the page. From there you will be asked to enter your three digit prefix which can be found on your ID card (NEM). From this site you may also find international providers.

How can I find out information about coverage that is supplemental to Medicare?
There are lots of Medicare choices, including Medicare+Choice, medical savings accounts and private fee-for-service plans. Contact your local BlueCross BlueShield representative for details regarding claims or coverage.

Prescription Drug

How do I participate in the mail order drug plan with Express Scripts?
Refer to information available online under Important Forms and Documents for specific instructions on how to enroll in the mail order plan.

What if I don’t want to enter my credit card number online in order to print off the mail order prescription drug form?
Associates can have an Express Scripts mail order packet mailed to them from the Nemours Customer Service Center (877-458-9699).
How can I find out if the brand name drug that I am taking has a chemical equivalent?
A listing of chemically equivalent drugs is difficult to maintain, because as brand name drugs lose their patents, new chemically equivalent generic drugs are manufactured.

However, you may visit www.drugdigest.org, and enter the name of your brand name drug in the “Search” field on the left hand side of the page. If a number of options appear, click the name of the drug that matches the prescription you are taking. Information about that prescription drug will then appear. In the bank of information available at the top of the page, look for “Generic Available”—if this field indicates “yes,” it means a chemically equivalent generic is available. If this field indicates “no,” it means no chemically equivalent generic drug is currently available.

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

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

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

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

I use mail order for my prescription drugs. Will the Generics Preferred Programs apply to my mail order medications?
Yes, these programs will apply to mail order.

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

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

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

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

What is a participating dentist and how do I locate one?
A general dentist or specialist who meets MetLife’s strict credentialing standards and accepts scheduled fees as payment-in-full for services rendered. You can get a list of participating dentists online at www.metlife.com/mybenefits.com or call 1-800-942-0854 to have a list faxed or mailed to you.

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

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

Do I need an ID Card?
No, you do not need to present an ID card to prove coverage or confirm that you are eligible. However, dental coverage and claims filing information is provided under Important Forms & Benefits Booklets.

Voluntary Vision

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

What will be covered through this benefit?
This vision benefit provides added discounts when services are sought through the preferred provider listing. See page 11 for a summary of vision care benefits.

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

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

My eyecare provider is out-of-network. How do I get reimbursed for my expenses?

Are my contact lenses “elective” or “necessary”?
If your contact lenses are considered medically necessary (in other words, you can’t wear glasses), they will be reimbursed at 100 percent.

If you have the option of wearing glasses or contacts, your contact lenses are considered “elective,” and you have a $130 allowance.
I need both glasses and contact lenses—what should I do?
Frames may only be reimbursed one year after filling a prescription for contact lenses. We therefore recommend that you fill your prescription for glasses and lenses FIRST, and then, in the following calendar year, fill a script for contact lenses.

Contact lenses/lenses are considered interchangeable, so you may EITHER receive $130 for lenses or for contacts in any given calendar year.

Are disposable contact lenses covered under this plan?
Yes. You may use your elective contact lens allowance toward disposable contact lenses. If your disposable lens charges are under the allowable amount for the calendar year, you may continue to be reimbursed for disposable lenses until you have reached the $130 allowance.

Thereafter, you may be eligible for discounts on your disposable lenses.

Are polycarbonate or bicarbonate lenses covered for adults?
Charges for polycarbonate or bicarbonate lenses are not covered under the normal lens co-pay. However, you may elect to pay the extra charge for poly- or bicarbonate lenses. In general, this charge will not exceed $32.

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

Under the soft contact lens program, instead of having a $130 allowance towards contacts AND the contact fitting exam, you will receive a 15 percent discount off the contact fitting exam, PLUS a $130 allowance towards contact lenses. This program will generally allow you to receive six months of soft contact lenses without cost.

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

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

Login Information

Step One: Enter your Username and Password

• BOTH your USERNAME and PASSWORD are the first letter of your first and last name and the last four digits of your Social Security Number with no dashes or spaces. For example: Joe Smith (123-45-6789) would be (user) “JS6789” (password) “JS6789”

• Your PASSWORD must be entered in ALL CAPS

Step Two: Enter your Date of Birth and the Login Identifier: NEMOURS

Step Three: Create a new Password

• Your new password must contain at least 8 characters and must contain at least 3 of the following 4 categories
  • Uppercase Letters: A,B,C,D,...
  • Lowercase Letters: a,b,c,d,...
  • Numbers: 1,2,3,4,5,6,7,8,9,0
  • Symbols: ! @ # $ % & _ ^ ` + { } | ~ , . = - |

Note: @@ and—are NOT allowed

• If you forget your new password, you may either correctly answer the security question to retrieve your password, or you may call 1-877-458-9699, OPTION 2, to request that your password be reset.
First Time Enrollment Information
You have 30 days from your date of hire to enroll.

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

- Dependent Names, Dates of Birth, and Social Security Numbers
- For your Spouse, your date of marriage
- For any Medicare Eligible dependents you plan to cover, Medicare enrollment information

You may log in as many times as you need to in order to complete your enrollment. However, once you submit your new hire elections, they cannot be changed online. Instead, complete a Benefits Enrollment Change form.

Site Summary
“My Homepage” provides important carrier contact information and links to websites.

“Benefits” tab provides an overview of the benefits available to you, your coverage levels, and contribution information.

“My Benefits & Personal Information” tab contains a summary of your employment information, your demographic information, and your coverage information. You may also designate beneficiaries and request ID cards from this tab.

“Forms” tab provides a one-stop resource for the majority of forms, booklets, plan summaries and information necessary to navigate your benefits program.
<table>
<thead>
<tr>
<th>Medical Plans (Group #113264)</th>
<th>Voluntary Long Term Care (Group #546735)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCross BlueShield of DE</td>
<td>UNUM</td>
</tr>
<tr>
<td>Wilmington, DE 19899-868</td>
<td>2211 Congress Street, LTC Department, A238</td>
</tr>
<tr>
<td>Telephone: 800-633-2563</td>
<td>Portland, Maine 04122</td>
</tr>
<tr>
<td>Web Site: <a href="http://www.bcbs.com">www.bcbs.com</a> or <a href="http://www.bluecares.com">www.bluecares.com</a></td>
<td>Telephone: 800-227-4165</td>
</tr>
<tr>
<td></td>
<td>Web Site: <a href="http://w3.unum.com/enroll/nemours">http://w3.unum.com/enroll/nemours</a></td>
</tr>
<tr>
<td>Health Advocacy</td>
<td>Disability (Policy number G600AJX2)</td>
</tr>
<tr>
<td>Health Advocate</td>
<td>Mutual of Omaha</td>
</tr>
<tr>
<td>Telephone: 866-695-8622</td>
<td>Telephone: 800-877-5176</td>
</tr>
<tr>
<td>Website: <a href="http://www.healthadvocate.com">www.healthadvocate.com</a></td>
<td>Web Site: <a href="http://www.mutualofomaha.com">www.mutualofomaha.com</a></td>
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<td></td>
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<tr>
<td>Prescription Drug Plans (Group #NEM)</td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td>Express Scripts</td>
<td>HFS Benefits</td>
</tr>
<tr>
<td>Telephone: 800-451-6245</td>
<td>164 Lakefront Drive</td>
</tr>
<tr>
<td>Web Site: <a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
<td>Hunt Valley, MD 21030</td>
</tr>
<tr>
<td></td>
<td>Telephone: 888-460-8005</td>
</tr>
<tr>
<td></td>
<td>Fax: 410-771-5533</td>
</tr>
<tr>
<td></td>
<td>Web Site: <a href="http://www.hfsbenefits.com">www.hfsbenefits.com</a></td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:claims@hfsbenefits.com">claims@hfsbenefits.com</a></td>
</tr>
<tr>
<td>Voluntary Vision Plan (Group # 30-010344)</td>
<td>Prepaid Legal Program (Group # 6090282)</td>
</tr>
<tr>
<td>VSP Vision</td>
<td>MetLaw</td>
</tr>
<tr>
<td>Telephone: 800-877-7195</td>
<td>Telephone: 800-821-6100</td>
</tr>
<tr>
<td>Web Site: <a href="http://www.vsp.com">www.vsp.com</a></td>
<td>Web Site: <a href="http://www.legalplans.com">www.legalplans.com</a></td>
</tr>
<tr>
<td>Email: <a href="mailto:imember@vsp.com">imember@vsp.com</a></td>
<td>(password for “Thinking About Enrolling” is “GetLaw”)</td>
</tr>
<tr>
<td>Dental Plans (Group #116718)</td>
<td>Employee Assistance Program (EAP)</td>
</tr>
<tr>
<td>MetLife</td>
<td>Delaware Family Center</td>
</tr>
<tr>
<td>Telephone: 800-942-0854</td>
<td>3608 Lancaster Pike</td>
</tr>
<tr>
<td>Web Site: <a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
<td>Wilmington, DE 19805</td>
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<td></td>
<td>Telephone: 888-636-6877 (888-NEMOURS)</td>
</tr>
<tr>
<td></td>
<td>Web Site: <a href="http://www.delawarefamilycenter.com">www.delawarefamilycenter.com</a></td>
</tr>
<tr>
<td>Basic &amp; Voluntary Life Plans (Policy #139430) and</td>
<td>Medical Information Helpline</td>
</tr>
<tr>
<td>Voluntary AD&amp;D (Policy #203020)</td>
<td>Allegeant (formerly Innovative Wellness Solutions)</td>
</tr>
<tr>
<td>Reliance Standard</td>
<td>Telephone: 800-582-1535</td>
</tr>
<tr>
<td>P.O. Box 8330</td>
<td>Wellness</td>
</tr>
<tr>
<td>Philadelphia, PA 19101-9759</td>
<td>Telephone: 877-293-2429</td>
</tr>
<tr>
<td>Telephone: 800-351-7500</td>
<td>Web Site: <a href="http://www.allegeant.net">www.allegeant.net</a></td>
</tr>
<tr>
<td>Web Site: <a href="http://www.rslj.com">www.rslj.com</a></td>
<td></td>
</tr>
<tr>
<td>Voluntary Critical Illness &amp; Universal Life</td>
<td>403(b) Retirement Savings Plan</td>
</tr>
<tr>
<td>Select Benefits Group &amp; TransAmerica</td>
<td>Diversified Investment Advisors</td>
</tr>
<tr>
<td>Telephone: 877-458-9699, Option 3</td>
<td>(Acct. # TT069349001)</td>
</tr>
<tr>
<td></td>
<td>4 Manhattanville Road</td>
</tr>
<tr>
<td></td>
<td>Purchase, NY 10577</td>
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<tr>
<td></td>
<td>Telephone: 888-676-5512 or 800-755-5801</td>
</tr>
<tr>
<td></td>
<td>Web Site: <a href="http://www.divinvest.com">www.divinvest.com</a></td>
</tr>
<tr>
<td>Nemours Human Resources Customer Service Center</td>
<td>For questions regarding the prior 403(b) vendors, the Nemours Foundation Pension Plan, or tuition reimbursement, or if your questions or concerns have not been resolved by the above carriers, please contact the customer service center (Option 1):</td>
</tr>
<tr>
<td>Telephone: 877-458-9699 • Fax: 866-261-9778 • E-mail: <a href="mailto:benefits@nemours.org">benefits@nemours.org</a></td>
<td>10140 Centurion Parkway North • Jacksonville, FL 32256</td>
</tr>
</tbody>
</table>
Group Insurance Brokers & Consultants Specializing in Healthcare

A Division of Kelly & Associates Insurance Group

301 International Circle • Hunt Valley, MD 21030

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