LYNN UNIVERSITY

Quality - Innovation - Support

2017 Guide to Benefits

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Please note that in the event of any variations between the summary descriptions provided in this guide and plan documents, the plan documents will govern.

Eligibility and Enrollment

Regular full-time Lynn University employees have the opportunity to enroll in any of the Lynn University-sponsored benefit plans. This guide will assist you as you consider the election options and employee contributions for you and your eligible dependents. You will also find instructions on how and when to make benefit elections.

Benefit Plans

- Medical
- Prescription
- Dental
- Vision
- Flexible Spending Accounts
- Short & Long-Term Disability
- Life Insurance and AD&D
- Educational Benefits
- Retirement
- Personal Health Advocate
- Supplemental Insurance
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Eligibility and Enrollment

Benefits Eligibility

As a Lynn University employee, you must meet certain criteria to become eligible and maintain benefit eligibility. To be eligible for benefits you must be a regular full-time employee working a minimum of 35 hours a week on a regular scheduled basis for a continuous and indefinite period of time.

When coverage begins

If you enroll for benefits, your coverage goes into effect on the first of the month following your full-time hire date. If you do not enroll by the deadline you will not be covered for the remainder of the plan year - through December 31. Your next chance to enroll will be during the next annual benefits open enrollment period.

However, if you have a qualifying life event during the year, you may be able change your benefits during the plan year, provided you contact Employee Services within 31 days of your event.

When coverage ends

Life insurance and Short & Long Term Disability coverage will end when your eligibility ends. Medical, dental and vision benefits will end on the last day of the month in which your eligibility ends. Some benefits may be continued, see below for more information.

	What Happens When You Lose Benefits Eligibility
Health Coverage • Medical • Dental • Vision	Your coverage (and coverage for your enrolled dependents) ends when your benefits eligibility ends. You may elect to continue your coverage under COBRA and pay the full cost of the coverage plus a 2% administration fee. You will be sent a COBRA enrollment kit shortly after your coverage ends.
Disability • Short-Term • Long-Term	Coverage ends when your benefits eligibility ends. If you have been approved for disability benefits prior to this date, your disability benefits will continue per plan provisions.
Life Insurance Accidental Death and Dismemberment	Coverage (and coverage for your enrolled dependents) ends when your benefits eligibility ends. You have 31 days from the date your coverage ends to convert your paid life insurance coverage to an individual policy, and to convert or port your supplemental life coverage.
Reimbursement Accounts • Flexible Spending • Dependent Care	Your participation ends as of your final contribution. If you have amounts remaining in your account, you may elect to continue your health care reimbursement account participation through the remainder of the plan year on an after-tax basis through COBRA.

Making Changes

When you enroll in or waive benefits your choices remain in effect for the entire plan year, which runs from January 1 to December 31. There are several situations that could automatically change some of your benefits or allow you to make changes to your enrollments. They are:

- During the annual benefits open enrollment period, or
- When you have a Qualifying Life Event

Eligibility and Enrollment

Annual open enrollment

Open enrollment is a time when you may make changes to your benefit elections for yourself and your eligible dependents. Changes you can make include, but are not limited to, changing your medical plan options, adding or dropping your eligible dependents and increasing or decreasing your life insurance coverage amount.

Enrollment changes are in effect the following plan year, from January 1 through December 31.

During open enrollment, Employee Services will email a summary of your current elections to your Lynn email address. Review this information and make any changes to your benefits enrollment during the open enrollment period.

What is a qualifying life event?

All of the following are considered 'Qualifying Life Events':

- Change in number of eligible dependents due to birth, adoption, placement for adoption or death.
- Gain or loss of eligibility for a dependent under a Lynn University plan.
- Change in legal marital or domestic partnership status, including marriage, divorce, start or end of a domestic partnership, annulment of a marriage or death of a spouse or domestic partner.
- Loss of benefits eligibility or coverage for your spouse or domestic partner or children, or loss of all contributions by another employer for coverage.
- Employment status changes for your spouse or domestic partner or children (specifically, starting or ending employment; starting or returning from an unpaid leave, or a change in a family member's work site) .
- Court order requiring health coverage for a dependent.

If you have a Qualifying Life Event during the plan year, you may be able to change your benefit elections. Your changes must also correspond to any changes your spouse, domestic partner or child makes to his or her coverage under another employer's plan.

To see whether your situation is eligible for a change in benefits, or to make changes to your benefit elections, contact Employee Services within 31 days of the event. Changes not submitted within the 31 day window will be postponed to the start of the next plan year.

Eligible Dependents

Eligible dependents are the people considered eligible for coverage under Lynn University's benefits:

- Your spouse
- Your same sex domestic partner
- Your dependent child(ren) up to age 26 for dental/vision coverage and up to age 26 for medical coverage (or age 30 for medical coverage if they meet certain criteria - refer to the plan documents).
- Your dependent child(ren) 19 years of age or older but incapable of self-support

Eligible Dependents (cont)

You can choose to cover eligible dependents under the medical, dental and vision plans if you also enroll for these plans. You have four coverage levels to choose from:

- Employee only
- Employee plus spouse or domestic partner
- Employee plus child(ren)
- Employee plus family

When you enroll a dependent in any of the health plans, you must choose the same plan for yourself and your enrolled dependents.

Coordination of benefits

You may have the opportunity to be covered under more than one medical or dental plan at a time (ie: Medicare, spouse/domestic partner's plan through another employer). Many health plans - including Lynn University's - are designed to prevent any overpayment of benefits when this happens. This is called coordination of benefits. Under this provision, the amount normally reimbursed under your health care plan is reduced to reflect payments made by another group plan. This means that in many cases you will receive little or no additional benefit from the second plan.

No dual coverage

You may not be covered under Lynn University's benefits plans as both an employee and a dependent. If you are related to or are the spouse or domestic partner of another employee, you must carry your own coverage. No child may be covered as a dependent of more than one Lynn University employee.

Your children

Your unmarried, dependent children are eligible for benefits until the end of the year in which they turn the maximum age for that specific benefit. Children are covered up to that age if the child is:

- Unmarried
- Does not have dependent(s) of their own
- Is a Florida resident or a full/part time student at an accredited higher education institution
- Not eligible for Medicare
- Does not have any other health coverage

Your dependent children under age 30 are eligible for coverage if they qualify for tax-free coverage under federal law. Your dependent children include:

- Biological children
- Foster children
- Step children
- Legally adopted
- Children placed with you for adoption

Your spouse

To be covered under Lynn University benefits, your spouse must be your lawful spouse, which means you must be legally married.

Your domestic partner

Lynn University covers same sex domestic partners as defined in this manual. Both you and your domestic partner need to satisfy all the requirements to be considered each other's domestic partner. If you enroll your domestic partner, you will be required to sign a declaration affirming your relationship and return it to Employee Services.

To be eligible for Lynn University benefits, you and your domestic partner must satisfy all of the following:

- Be age 18 or older
- Are not related by blood or closer than would otherwise prohibit legal marriage in the state of residence
- Be the same sex as the employee
- Live together permanently for at least 12 consecutive months
- Are jointly responsible for basic living expenses
- Are each other's sole domestic partner
- Share financial interdependence, evidenced by at least 4 of the following:
    - Joint bank account
    - Joint credit card
    - Joint residence ownership/lease
    - Joint household expenses
    - Granted power of attorney designating each other as sole beneficiary/executor
- Have joint responsibility for each other's welfare
- Not legally married to or separated from each other, or anyone else, nor have had another domestic partner or spouse within the last 12 months.

If you enroll and certify an individual as your domestic partner who does not meet the criteria to be considered eligible under Lynn University plans, you will be subject to corrective action which may include termination of employment.

Domestic partner limitations

Most Lynn University benefits plans consider your domestic partner as your qualified dependent, as long as your domestic partnership meets the definition described in this section. However, there are some exceptions.

- **Flexible Spending Accounts:** Expenses incurred for your domestic partner who is not considered your tax dependent may not be reimbursed through the health care and dependent care flexible spending accounts.

Taxation of domestic partner benefits

When you enroll your domestic partner or your domestic partner's children in Lynn University health benefits, you will be taxed on the value of their coverage, as required by the Internal Revenue Service (IRS), unless the covered individuals satisfy the Internal Revenue Code definition of dependent.

Your domestic partner (cont)

Your payroll deduction and the amount that Lynn University contributes towards your domestic partner's coverage are taxable to you as imputed income.

Who Is Not Considered A Dependent

Your parents, roommates, sisters and brothers - even if they live with you - do not qualify as dependents under Lynn University benefit plans; nor do your grandparents, nieces, nephews or anyone else who does not meet Lynn University's definition of an eligible dependent.

Proof of dependent status

If you enroll a dependent in a Lynn University benefits plan, we may ask you at any time for proof that your dependent meets the definition of an eligible dependent as previously outlined. Examples of acceptable documentation to establish your dependent's relationship include but are not limited to:

- Marriage certificate
- Domestic partner affidavit
- Court documents
- Birth certificate
- Adoption order

If it is determined that the individual(s) you enrolled does not qualify as a dependent, Lynn University will take corrective action, which may include termination of employment.

Benefit Enrollment

You can enroll for benefits coverage upon reaching initial eligibility, during annual open enrollment period or within 31 days of a qualifying life event. Once you have established initial eligibility at Lynn University, you can enroll for the benefits you choose, and you can enroll your eligible dependents. The coverage you elect will remain in place through the end of the plan year (December 31) - unless you have a qualifying life event during the year.

While On Approved Leave Of Absence

Your eligibility for benefits while on an approved leave of absence will vary depending on the reason for your leave, your length of leave and your benefits eligibility status.

Personal leave

As during active employment, you must continue to be paid the minimum hours for ongoing eligibility to maintain or re-establish benefits eligibility during a personal leave. Personal leave does not extend your benefits eligibility or coverage.

Family/medical and disability leave

If you are benefits eligible at the start of your approved family/medical or disability leave, your benefits eligibility will be affected as follows:

While On Approved Leave Of Absence (cont)

- If your leave does not exceed the maximum allowed under law and is approved by Lynn University, your benefits eligibility will continue through the end of the month in which you reach the maximum amount of continuous family/medical and/or disability leave. No more than the maximum amount of benefits eligibility will be allowed for a continuous family/medical and/or disability leave.
- If your leave exceeds the maximum amount, your eligibility will be cancelled at the end of the month in which your leave ends.

Upon return to work from an approved family/medical or disability leave, your benefits eligibility and coverage will be reinstated the first of the month following your return to work.

Generally, changes to your coverage while on leave are not allowed unless you experience a qualifying life event or during annual open enrollment. Changes to life insurance (including spouse or domestic partner and child life coverage), accidental death and dismemberment insurance, and long-term disability elections are only allowed when you are actively at work.

When Your Employment Ends

The following chart outlines what happens when your employment at Lynn ends.

BENEFIT	What Happens When You Lose Benefits Eligibility
Medical Dental Vision	Coverage ends on the last day of the month in which your separation is processed by payroll. You may elect to continue your coverage under COBRA.
Flexible Spending Dependent Care	Your participation ends as of your final contribution. If you have amounts remaining in your account, you may elect to continue your participation through the end of the plan year in which you participate on an after-tax basis through COBRA.
Short-Term Long-Term	Coverage ends when your benefits eligibility ends. If you have been approved for disability benefits prior to this date, your disability benefits will continue per plan provisions.
Life Insurance Accidental Death and Dismemberment	Coverage (and coverage for your enrolled dependents) ends when your benefits eligibility ends. You have 31 days from the date your coverage ends to convert your paid life insurance coverage to an individual policy, and to convert or port your supplemental life coverage.
Employee Scholarship Tuition Exchange	Coverage ends (for employee and enrolled dependents) at the end of the semester in which your benefits eligibility ends.

Medical Plans

Point of Service (POS)

This plan (Aetna Choice POS) offers a large choice of physicians and hospitals and provides out of network benefits.

Health Maintenance Organization (HMO)

This plan (Aetna HMO) offers the benefit of fixed out-of-pocket expenses to the member, but provides limited out-of-network coverage.

Health Savings Account (HSA)

This plan (Aetna HSA) pairs health coverage with a tax-free health savings account. This is a consumer-driven health care plan that gives the member more control over how health care dollars are spent.

Lynn University offers three types of medical plans (POS, HMO and HSA) to employees, based on the availability of these plans and their networks. All of the University-sponsored plans are comprehensive in nature.

The plans vary in terms of where you receive care, which medical expenses are covered and how much the plans cost. You decide which plan best meets your needs.

Aetna
800.445.5299

Point of Service Plan (POS)

This plan (Aetna Choice POS) offers the largest choice of physicians and hospitals. You do not have to select a Primary Care Physician (PCP) to manage your care. If you go to an In-Network provider, the plan will pay higher benefits. If you go to an Out-of-Network provider the plan will pay lower benefits. The POS plan has yearly deductibles and modest co-pays that must be met before full benefits are paid.

Health Maintenance Organization (HMO)

This plan (Aetna HMO) generally has the lowest cost to the member (no deductible and modest co-pays), but provides limited out-of-network coverage. You must select a Primary Care Physician (PCP) for each covered family member to meet your primary health care needs. All services require an approval by the PCP. Members who see a PCP, other than their designated or selected PCP may be denied coverage and/or delay claim payment.

Health Savings Account (HSA)

The Health Savings Account (HSA) is health coverage, plus a health savings account rolled into one - with tax benefits. This plan has 2 components:

- Health Savings Account
- High Deductible Health Plan (HDHP)

The HSA portion is a Tax-Free savings account that contains employee and employer contributions. Employees receive a debit card which they may use to pay qualified medical expenses, including co-pays, prescriptions and deductibles.

The HDHP portion is a consumer-driven health care plan that offers preventive care benefits only. All other services are subject to a high annual deductible. Once the deductible has been met, most services are covered at 90%.

Which Medical Plan Is Best?

Employees often ask this question. Choosing a medical plan is a personal decision that should be based on the unique medical needs and preferences of each employee. Each type of medical plan has features that may be considered advantageous by some employees or limited by others. No one can tell you which plan to select, but below are some areas that you will want to consider:

Provider Network

- What network does the plan use?
- Are your providers in the network?
- Does the plan have Out-of-Network benefits?
- If your providers are not In-Network, are you willing to change providers? (Out-of-Network costs)
- Is the network a local or national network?
- If you travel extensively or have family members living away from home, will the network meet your needs?

Which Medical Plan Is Best? (cont)

Covered Services

- All plans cover most recommended preventive services with no co-pay or deductible. These services include mammograms, childhood immunizations, annual physicals, pap tests, and most other commonly recommended screening tests.
- All plans cover a comprehensive eye exam without a deductible once every 2 years.
- Do you have special needs such as medical equipment, prosthetics, therapies, or skilled nursing? If so, you will want to ask how these are paid in the plans you are considering.

What You Pay

Your contributions toward medical coverage are automatically deducted from your paycheck each pay period. In addition to these payroll deductions, you may have some out-of-pocket costs when you receive medical care. These costs include deductibles, co-pays and co-insurance your medical plan may require before it starts paying benefits.

What Is A Deductible?

A deductible is the amount you pay each calendar year toward the cost of medical expenses before most of the medical plans begin paying benefits. You may have an individual, per person deductible to meet, or a family deductible that you pay for all of your covered family members combined. Additionally, if you are enrolled in a plan that requires use of a network, you will likely have a separate in-network and out-of-network deductible.

What Is A Co-Pay?

Some of the medical plans have co-pays. A co-pay is a flat fee you pay for each office visit with an in-network provider. Any remaining charges for that visit are usually covered in full by your medical plan. Other services may have a co pay as outlined in this guide.

What Is Co-Insurance?

Co-Insurance refers to the percentage of a medical expense paid by either you or your Lynn University medical plan. For example, the plan may pay 80% of a $1,000 medical procedure. Your responsibility (or co-insurance) would be the remaining 20%. The co-insurance applies after you meet any plan deductibles.

Your Reimbursement Account Covers Medical Expenses

If you have a reimbursement account and have out-of-pocket medical expenses, you may be reimbursed for these expenses from your account. Expenses include your deductibles, co-pays and may include charges not covered by the medical plan. Refer to the Reimbursement Accounts section for more information.

What Is A Maximum Lifetime Benefit?

A maximum lifetime benefit is the most a medical plan will pay for an individual over his or her lifetime. The maximum lifetime benefit by plan is shown below:

Plan	In-Network	Out-Of-Network
Aetna HMO	Unlimited	Unlimited
Aetna POS	Unlimited	Unlimited
Aetna HSA	Unlimited	Unlimited

The lifetime maximum benefit includes benefits paid for mental health and chemical dependency treatment, but excludes prescription drug benefits.

Calendar Year Out-of-Pocket Maximum

The calendar year out-of-pocket maximum is the most you or your enrolled dependents must pay toward covered medical expenses in a calendar year. The in-network and out-of-network annual out-of-pocket maximums are separate and not combined. The following charges are not considered when calculating your out-of-pocket maximum:

- Charges in excess of recognized charges
- Charges for expenses not covered by the plan
- Expenses for nicotine-use treatment programs
- Expenses for temporomandibular joint disorder (TMJ)
- Nonpreferred prescription expenses

The annual out-of-pocket maximums are as follows:

Plan	In-Network	Out-Of-Network
Aetna HMO	$1,500 Individual $3,000 Family	Not Covered
Aetna POS	$1,500 Individual $4,500 Family	$3,000 Individual $9,000 Family
Aetna HSA	$2,500 Individual $5,000 Family	$10,000 Individual $30,000 Family

Claims

When you visit an Aetna network provider, claims will be handled by your provider. You simply pay your co-pay when you receive services. For services that you pay a percentage of the fee, Aetna will send you an Explanation of Benefits after the claim is processed that will tell you how much of the bill you owe.

When you visit an out-of-network, provider for medical services, either you or your doctor must file a claim to receive benefits from the plan.

	Aetna HSA Plan In-Network - Out-of-Network	Aetna HMO Plan	Aetna POS Plan In-Network - Out-of-Network
Annual Deductible Individual/Family	$1,500/$3,000-$5,000/$15,000	None	$500/$1,500 - $1,000/$3,000
Preventive Care			
Routine Physical/Immunization	$0 - Not Covered	$0	$0 - Not Covered
Well Child Exam/Immunization	$0 - 40% After Ded	$0	$0 - 30% up to age 16
Routine Gyn Care Exam	$0 - 40% After Ded	$0	$0 - Not Covered
Routine Mammogram	$0 - 40% After Ded	$0	$0 - 30% Coinsurance
PSA/Colorectal Cancer Screen	$0 - Not Covered	$0	$0 - Not Covered
Routine Eye Exam	$0 - 40% After Ded	$0	$0 - 30% After Ded
Routine Hearing Screen	$0 - Not Covered	$0	$0 - Not Covered
Physician Services	**After Deductible**		
Physician Office Visit	10% - 40%	$20 Copay	$20 Copay - 30% Coinsurance
Specialist Office Visit	10% - 40%	$30 Copay	$30 Copay - 30% Coinsurance
Maternity Services	10% - 40%	$30 Copay - Initial Visit Only	$30 Copay - 30% Coinsurance
Allergy Testing/Treatment	10% - 40%	$30 Copay	$30 Copay - 30% Coinsurance
Hospital Services	**After Deductible**		
Inpatient Care	10% - 40%	$500 Copay per admission	$500 Copay after Ded - 30% Coins
Maternity Inpatient	10% - 40%	$500 Copay per admission	$500 Copay after Ded - 30% Coins
Outpatient Surgery	10% - 40%	$100 Copay	$0 After Ded - 30% Coinsurance
Urgent Care	10% - 40%	$50 Copay	$100 Copay - 30% Coinsurance
Emergency Room	10% - 10%	$150 Copay	$150 Copay - $150 Copay
Ambulance	10% - 10%	Covered 100%	100% After Ded - 100% After Ded
Diagnostic Procedures	**After Deductible**		
Diagnostic Lab and X-Ray	10% - 40%	$30 Copay	$30 Copay after Ded - 30% Coins
Complex Imaging Services	10% - 40%	Covered 100%	$0 after Ded- 30% Coinsurance
Mental Health Services	**After Deductible**		
Inpatient Mental Health	10% - 40%	$500 Copay per admission	$500 Copay after Ded - 30% Coins
Outpatient Mental Health	10% - 40%	$30 Copay	$30 Copay - 30% Coinsurance
Alcohol/Drug Abuse	**After Deductible**		
Inpatient Detox	10% - 40%	$500 Copay per admission	$500 Copay after Ded - 30% Coins
Outpatient Detox	10% - 40%	$30 Copay	$30 Copay - 30% Coinsurance
Inpatient Rehab	10% - 40%	$500 Copay	$500 Copay - 30% Coinsurance
Outpatient Rehab	10% - 40%	$30 Copay	$30 Copay - 30% Coinsurance

Medical Plans

	After Deductible		
Other Services			
Skilled Nursing Facility	10% - 40%	Covered 100%, 100 days PCY	100% after Ded - 30%, 60 days
Home Health Care	10% - 40%	Covered 100%[#], 60 days PCY	100%[#] after Ded- 30% Coinsurance [##]
Hospice Care In/Outpatient	10% - 40%	$500 Copay/Covered 100%	$500 Copay/100% - 30% Coinsurance
Outpatient Rehab Therapy	10% - 40%	$30 Copay	$30 Copay - 30%, 30 visits PCY
Chiropractor	10% - 40%, 20 visits PCY	$30 Copay 20 visits PCY	$30 Copay - 30%, 20 visits PCY
Durable Medical Equipment	0% or Not Covered- 40%	Covered 100%	20% - 30% Coinsurance after Ded
Diabetic Supplies	10% - 40%	See Pharmacy	See Pharmacy - 30% Coinsurance
Transplants	10% - 40%	$500 Copay	$500 Copay - 30% Coinsurance
Family Planning			
Infertility	Based on service type/place	Based on service type/place	Based on service type/place

[#] **Limit 3 visits per day** [##] **20 visits per calendar year**

Coverage Level	HSA Bi-Weekly Rates	HMO Bi-Weekly Rates	POS Bi-Weekly Rates
Employee Only	$ 50.72	$ 59.46	$119.97
Employee + Spouse/DP	$116.50	$132.54	$267.46
Employee + Children	$ 93.62	$103.92	$209.73
Employee + Dependents	$152.70	$181.33	$365.90

Annual Max Contribution for HSA*:

Individual	$3,400
Family	$6,750
55 or older	$1,000 catch-up

*regulated by the IRS

Lynn University Annual Contribution to the HSA (disbursed on a biweekly basis):

Individual	$1,000
Employee + Spouse	$2,500
Employee + Children	$2,500
Family	$2,500

Tools & Information on Aetna.com

Aetna provides you with online health and benefits information 24 hours a day, seven days a week. Through Aetna Navigator you can:

- Search the Aetna DocFind® Provider Directory for a primary care physician (PCP) and other network providers
- Change your PCP
- Order replacement ID cards
- View benefits information, including your PCP designation
- View claims status and, when available, your Explanation of Benefits (EOB)
- Compare hospitals
- Get prices for various medical procedures
- Access information about other Aetna products and programs
- Link to other online health resources and tools that help you make better health decisions
- Print a health history for your own reference or for discussions with your doctor
- Obtain a claims summary and use the data for tax needs, or for determining what you may owe a particular provider

ID Cards

When you enroll in a medical plan, an ID card will be mailed to your home. You need to present this card whenever you visit your doctor, medical facility or participating pharmacy for services. If you do not receive an ID card within a month after enrolling or if you need additional or replacement ID cards, call Aetna at 800-445-5299 or visit www.aetna.com.

Questions?

For answers to your questions about the medical plan or for more information on services, or supplies, please contact Aetna Member Services at 800-445-5299 (POS and HSA) or 877-402-8742 (HMO).

Prescription Drug Plan

Aetna Rx Plan

If you are enrolled in any of the medical plans, then you are automatically enrolled in the Prescription Drug Plan.

As long as you are enrolled in a Lynn University medical plan administered by Aetna, the prescription drug plan will cover you and your enrolled dependents when you need a prescription filled.

Aetna
800.843.3661

How The Plan Works

If you are enrolled in any of the medical plans, you must visit a participating pharmacy to receive coverage for any prescription filled. Aetna contracts with a number of large nationwide pharmacy chains, as well as local independent pharmacies, so you have lots of options when it comes to filling a prescription.

And, to save even more money and time you can use Aetna Rx Home Delivery if your prescription is for a maintenance medication written for a 90-day supply. Maintenance medications are those prescription drugs that are taken on a routine, ongoing basis.

	Participating Providers	Non-Participating Providers	Aetna Rx Home Delivery 90 Day Supply
POS	Up to 30-day supply 100% after you pay: • $10 Copay for generic formulary • $30 Copay brand-name formulary • $50 Copay for brand-name non-formulary • 10% for injectables formulary and non-formulary*	• Not Covered	100% after you pay: • $20 Copay for generic formulary • $60 Copay brand-name formulary • $100 Copay for brand-name non-formulary • 10% for injectables formulary and non-formulary*
HMO	Up to 30-day supply 100% after you pay: • $10 Copay for generic formulary • $30 Copay brand-name formulary • $50 Copay for brand-name non-formulary • 10% for injectables formulary and non-formulary*	• Not Covered	100% after you pay: • $20 Copay for generic formulary • $60 Copay brand-name formulary • $100 Copay for brand-name non-formulary • 10% for injectables formulary and non-formulary*
HSA	Up to 30-day supply After meeting deductible: • $10 Copay for generic formulary • $30 Copay brand-name formulary • $50 Copay for brand-name non-formulary	• Not Covered	After meeting deductible: • $20 Copay for generic formulary • $60 Copay brand-name formulary • $100 Copay for brand-name non-formulary

*First prescription fill at any retail or mail order facility.
Subsequent fills must be through Aetna Specialty Pharmacy

Prescription Drug Plan

What is a prescription drug?

- Prescription drugs include, but are not limited to a drug, biological compound prescription or contraceptive device which, by federal law, may be dispensed only by prescription.
- An injectable contraceptive drug prescribed to be administered by a paid health care professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid health care professional (covered injectable drugs include insulin).
- Disposable needles and syringes which are purchased to administer a covered injectable prescription drug.
- Disposable diabetic supplies.

What is a co-pay?

The prescription drug co-pay is the amount you pay to the participating pharmacy each time a prescription drug is dispensed to you. The co-pay applies to each prescription or refill. For medications dispensed as packaged kits, the co-pay applies to each kit.

What is formulary?

A formulary is a list of generic and brand-name drugs that are included in your medical plan's list of preferred medications. Drugs on the formulary list have gone through an extensive review process. Your prescription drug co-pay is lower when you use the formulary. If you are enrolled in a Lynn medical plan administered by Aetna, you can visit Aetna's website.

Generic vs. brand-name drugs

Prescription drugs are either generic or brand-name medicines. Generic drugs have the same active ingredients as brand-name drugs, and are dispensed in the same form and recommended dosage as the brand-name equivalent. The difference is that generics cost substantially less.

Brand-name drugs are produced by the original manufacturer and usually cost much more than a generic alternative, when available.

You pay a higher co-pay for brand-name drugs than for generics. The highest drug co-pay is for nonformulary brand-name drugs, which are drugs that are not on the formulary list.

Your Flexible Spending Account Covers Rx Expenses

If you have a Flexible Spending Account (HCFSA or HSA) and have out-of-pocket prescription expenses, you may be reimbursed for these expenses from your account. Out-of-pocket expenses include your co-payment, over the counter drugs with prescription, and may include charges not covered by the prescription plan. Refer to the Flexible Spending Accounts section for more information.

Aetna Rx Home Delivery

The mail-order drug program is part of your prescription drug benefit and is an easy, lower-cost way to obtain prescription drugs you use on a regular basis, such as oral contraceptives, diabetes or heart medicine. You can receive up to a 90-day supply by mailing in your co-pay with your prescription. Once your initial prescription is filled through Aetna Rx Home Delivery, you can easily order refills over the phone, through the mail or online. Prescriptions filled through Aetna Rx Home Delivery generally take from one to two weeks to arrive.

For more information about filling a new prescription through Aetna Rx Home Delivery, call the program directly at 866-612-3862. For questions about coverage of a particular medication, call Aetna Member Services at 888-318-2346.

What Is Not Covered

These drugs or supplies are not covered by your prescription drug benefits:

- Devices of any type, unless specifically included as prescription drugs
- Contraceptive drugs, except oral contraceptives
- Appetite suppressants
- Nutritional supplements
- Immunization agents
- Biological sera and blood products
- Any drug that has an over-the-counter equivalent
- Self-injectable allergy sera/extracts
- A supply for more than 30 days per prescription for each refill, unless provided by Aetna Rx Home Delivery
- Any refill of a drug if it is more than the number of refills specified by the prescriber
- Any refill of a drug dispensed more than one year after the date of the prescription
- Any drug provided by a health care facility or while you are an inpatient in any health care facility
- Administration or injection of any drug
- Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy
- Performance, athletic performance or lifestyle enhancement drugs or supplies
- Nonprescription drugs, vitamins, herbs, etc.
- Illegal drugs
- Experimental drugs
- Immunizations for foreign travel
- Drugs prescribed by an unlicensed health care provider
- Any item not covered under the medical plans

Participating Pharmacies

When you visit a participating pharmacy there is no need to submit a claim form. Simply present your Aetna ID card at the time you are ordering your prescription and make the necessary co-pay. Pharmacies participating in the Aetna network include a variety of independent pharmacies, as well as local and national chains.

To find a listing of participating pharmacies, you can contact Aetna Member Services or visit www.Aetna.com.

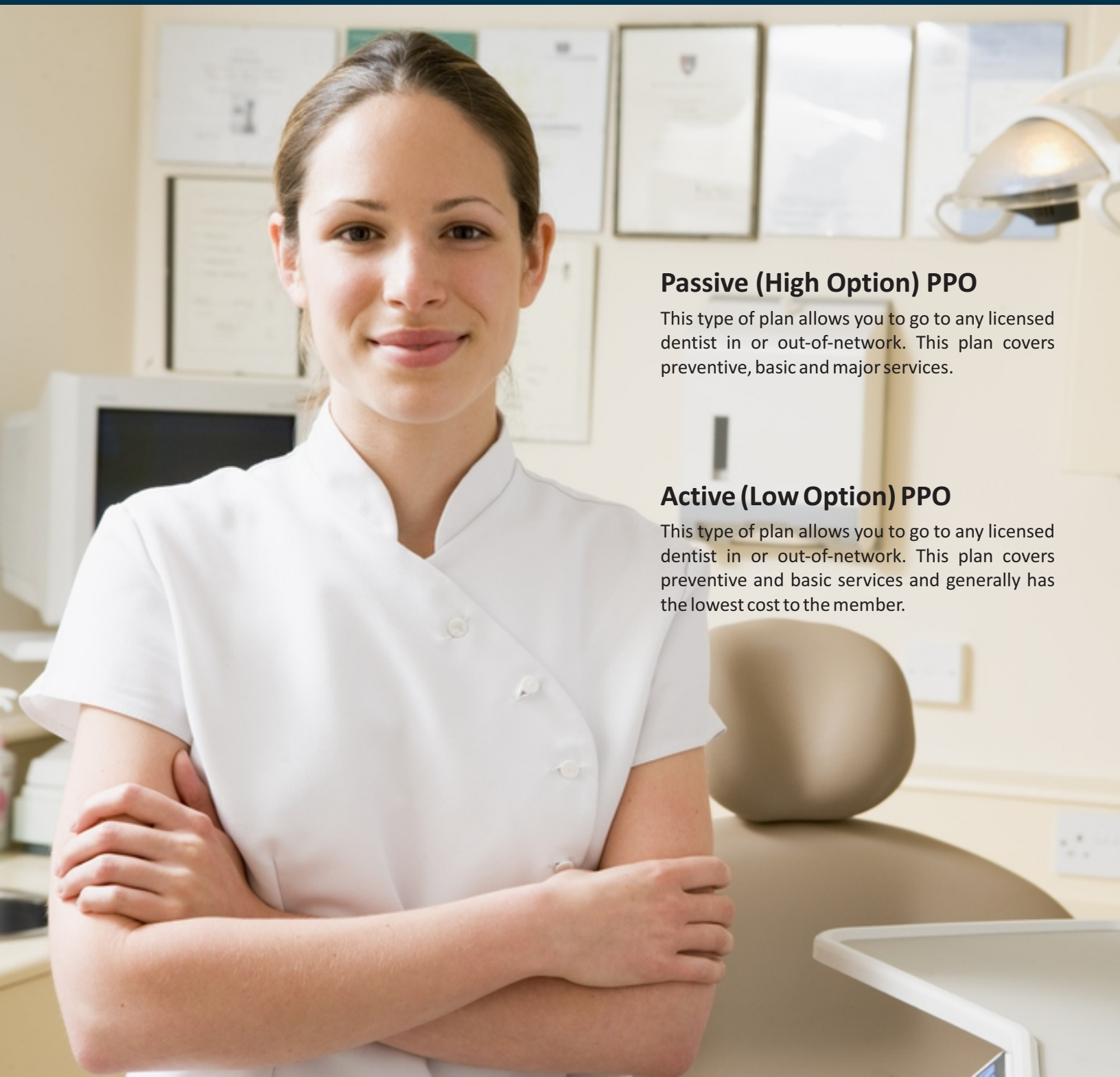
Questions?

For general questions about your prescription drug benefits, call Aetna Member Services at 888-318-2346. If you have specific questions related to coverage of a prescription drug, to find out more about having a new prescription filled through the mail-order program, or to ask questions about your mail-order refill, call Aetna Rx Home Delivery directly at 866-612-3862.

Dental Plans

Lynn University offers two dental care plans to employees, based on the availability of these plans and their network. Both of the Lynn University-sponsored plans are comprehensive in nature. Lynn University's dental plan, administered by Aetna, helps you pay for a wide range of dental expenses. Pay less when you visit a preferred dentist.

Aetna Dental
877.238.6200



Passive (High Option) PPO

This type of plan allows you to go to any licensed dentist in or out-of-network. This plan covers preventive, basic and major services.

Active (Low Option) PPO

This type of plan allows you to go to any licensed dentist in or out-of-network. This plan covers preventive and basic services and generally has the lowest cost to the member.

How the Plan Works

To receive dental coverage, you must be enrolled in the dental plan, as described in the Eligibility and Enrollment chapter. When you receive dental care you may also have some out-of-pocket costs. Your dental plan may require you to pay these expenses before benefits are paid.

Both of Lynn's dental plans cover the cost of basic and preventive dental care. Depending on the plan you choose, it may cover charges for dental services and supplies, if you need treatment for a dental disease or injury, and child orthodontia expenses.

After satisfying a calendar year deductible, the plan pays a percentage of recognized charges, depending on the plan and type of service you receive. You pay the remaining balance. If your dentist's charges exceed recognized charges, you pay the balance due after any plan payments. If you use a Aetna preferred dentist, most charges are considered within recognized charges.

Calendar year deductible

A deductible is the amount you pay each calendar year before benefits are paid for covered dental expenses. The deductible does not apply to preventive services. The calendar year deductible is $50 per covered person. The maximum calendar year deductible for your entire family is $150.

Recognized charges

A recognized charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it.
- The charge Aetna determines to be appropriate, based on such things as the cost for the same or a similar service or supply and the way in which it was billed, for example.

ID cards

After you enroll, you can print a card directly from Aetna.com. Registration is required. Take this card with you every time you visit the dentist.

Providers you can use

You can receive care through any licensed dentist. However, if you choose to receive care from a dentist in Aetna's preferred dentist network you will pay less for dental care. You do not need to select a preferred dentist at the time you enroll, but you will save money each time you visit a preferred dentist for dental care.

You can locate a preferred dentist by visiting www.aetna.com or by contacting Aetna Member Services at 800-843-3661.

Covered dental services

Lynn University's dental plan covers treatments that are necessary, considered appropriate, used nationwide and meet broadly accepted national standards of dental practice. You may be required to pay for services when you receive them, then file a claim for reimbursement from the plan.

The coverage you receive under the plans for preventive, basic and major dental care and child orthodontia is summarized in the overview chart on the following pages.

Your Reimbursement Account covers dental expenses

If you have a reimbursement account and have out-of-pocket dental expenses, you may be reimbursed for these expenses from your account. Out-of-pocket expenses include your dental deductibles and payment percentage and may include charges not covered by the dental plan. Refer to the Reimbursement Accounts section for more information.

Passive (High Option) PPO Plan

This type of plan allows you to go to any licensed dentist in or out-of-network. The deductible is waived for Preventive Services. Coverage is limited to those treatments that are necessary to prevent, diagnose or treat dental disease, defect or injury. There is a $2,000 annual maximum for Preventive, Basic and Major services, plus $1,500 of child orthodontia benefits.

Active (Low Option) PPO Plan

This type of plan allows you to go to any licensed dentist in or out-of-network. This plan generally has the lowest cost to the member. There is a $1,000 annual maximum for Preventive, Basic and Major Services combined. The deductible is waived for Preventive Services. This plan does not provide child orthodontia benefits. Coverage is limited to those treatments that are necessary to prevent, diagnose or treat dental disease, defect or injury.

Which Dental Plan Is Best?

When considering dental plans, it is important to note that the Active (Low Option) PPO Dental Plan primarily covers basic services such as appointments, diagnostics, preventive care, endodontic and basic restorative and basic resin restoration. If you think that you or your dependents may need major dental services, it is strongly recommended that you and/or your dependents consider the Passive (High Option) PPO Dental Plan.

Dental Plans

	Active (Low Option) PPO In-Network	Active (Low Option) PPO Out-Of-Network	Passive (High Option) PPO In/Out-Of-Network
Deductible (waived for Preventive Services)	$50 Individual/$150 Family	$50 Individual/$150 Family	$50 Individual/$150 Family
Annual Maximum (all services combined)	$1,000	$1,000 (combined w/ in-network)	$2,000
Preventive Services • Emergency palliative treatment • Oral Exam, teeth cleaning(every 6 months) • X-Rays	100%	100%	100%
Basic Services • Fillings (amalgam), crowns (stainless) • Root canals, impactions • Denture repair, bridgework • Periodontal services	80%	50%	80%
Major Services • Pontics, crown buildups • Dentures - full and partial, repairs • Inlays, onlays, posts	30%	30%	50%
Orthodontic Services ($1,500 Lifetime Max)	Not Covered	Not Covered	Child up to age 20

Coverage Level	Active (Low Option) PPO Bi-Weekly Rates	Passive (High Option PPO Bi-Weekly Rates
Employee Only	$ 8.21	$13.66
Employee + Spouse	$22.34	$33.21
Employee + Children	$25.35	$44.14
Employee + Dependents	$39.49	$63.53

Maximum Benefit Per Calendar Year

The maximum benefit that will be paid by the Lynn dental plan for preventive, basic and major services each calendar year per covered person is:

- $1,000 per calendar year under the Active (Low Option) PPO plan
- $2,000 per calendar year under the Passive (High Option) PPO Plan

The maximum lifetime benefit that will be paid for child orthodontia services is $1,500 per covered person on the Passive (High option) PPO plan.

Coordination Of Benefits

If you are part of a two-income family, you may be covered under more than one dental plan. To avoid duplicating benefits, most dental plans - including Lynn - have what is called a coordination of benefits provision. Under this provision, the amount normally reimbursed under your health care plan is reduced to reflect payments made by another group plan. This means that in many cases you will receive little or no additional benefit from the second plan.

What Are Necessary Services?

Necessary services for Lynn dental plans are those Aetna determines are necessary for the diagnosis, treatment or care of a sickness or injury. The plan will pay benefits for charges that have been shown to be necessary.

To be considered necessary, the service or supply must be for treatment, care or diagnosis that is:

- As likely to help your sickness or injury as any other alternative treatment or care
- Equal in quality to, and is not costlier than, any other alternative treatment, care or diagnosis

When determining necessary services or supplies, Aetna considers factors such as the patient's health condition, reports and guidelines published by nationally recognized health care organizations and professionals, information from medical literature and more.

What Is Not Necessary?

The following items are not considered necessary:

- Services or supplies that do not require the technical skills of a medical or dental professional
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, caretaker, family, health care provider or health care facility
- Services or supplies provided while you are being treated as an inpatient but when you could receive treatment, care or diagnosis as an outpatient
- Services or supplies furnished because of the setting when they could be safely and adequately provided in a physician's or dentist's office or another less costly setting

What Is Not Covered

The following services are not covered by the dental plan but may be covered, at least in part, by your Lynn medical plan, if enrolled. Lynn medical plans administered by Aetna may cover eligible expenses for treatment of certain conditions of the teeth, mouth, jaws, jaw joints or supporting tissues (including bones, muscles and nerves).

TMJ or MPD treatment

Lynn dental plan does not cover temporomandibular joint disorder (TMJ) or myofacial pain dysfunction (MPD) treatments. Nonsurgical treatments may be covered by Lynn medical plans administered by Aetna if treatment is medically necessary.

Other items not covered

The dental plans do not cover the following items:

- Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures
- Replacement of a lost, missing or stolen prosthetic device . Services or supplies to increase vertical dimension, including dentures, crowns, inlays, onlays, bridgework and any other appliance or service intended to increase vertical dimension
- Charges for which you are not legally obligated to pay
- Charges for the treatment of any condition related to or arising from previous or current employment or occupation, or serving in the armed forces
- Expenses in excess of recognized charges, as determined by Aetna
- Charges for services and supplies that are not necessary for the diagnosis, care or treatment of the condition, as determined by Aetna (this applies even if they are prescribed, recommended or approved by your doctor or dentist)
- Charges for treatment, services or supplies that are not prescribed, recommended and approved by your attending doctor or dentist
- Surgical procedures to correct malocclusion
- Experimental procedures
- Occupational diseases or injuries

What Is An Experimental Procedure?

A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- If required by the FDA, approval has not been granted for marketing;
- Services or supplies provided while you are being treated as an inpatient but when you could receive treatment, care or diagnosis as an outpatient; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.

Predetermination Review

A Predetermination Review is required for any dental services that exceed $350. This typically includes most basic and all major and orthodontic services. The purpose of predetermination is to inform you and your dentist, in advance, of what the plan covers for the proposed treatment prior to any coordination of benefits. If alternative services and supplies may be used to treat your dental condition, the plan will cover the least costly, professionally appropriate treatment.

To obtain predetermination, have your dentist fax your treatment plan to Aetna note that it is a predetermination review and Aetna will let your dentist know what benefits would be payable (this includes orthodontic treatment if your plan includes it).

Questions?

For general questions about your dental benefits, claims, provider directory or call Aetna Member Services at 800-843-3661.

Vision Plan

Lynn University provides its full-time employees with a free comprehensive vision plan. Dependent coverage can be elected at an additional cost. EyeMed was selected as the provider for its rich benefit and extensive provider network.

EyeMed Vision Care
866.299.1358

How The Plan Works

Lynn University's vision plan provides you and your enrolled dependents coverage for eye exams, prescription glasses and contacts. The plan is offered through EyeMed Vision Care which has a national network of eyecare providers.

To receive vision coverage, you must be enrolled for vision benefits as described in the Eligibility and Enrollment chapter.

When you visit an EyeMed Vision Care network provider, you will typically receive a higher level of coverage from the plan. If you choose to visit a non-network provider, some services may not be covered and for others you may not receive as high of a benefit. In addition, with a non-network provider you must pay for services up front and submit a claim to EyeMed Vision Care for reimbursement.

Finding a provider

There are several ways to access an EyeMed Vision Care network provider:

- Call EyeMed Vision Care Customer Service Department at 866-299-1358, and request a listing of network providers in your area.
- Visit the EyeMed Vision Care website at www.eyemed.com.

Visiting a network provider

To visit an EyeMed network provider just follow the steps outlined below:

- Select a provider in the EyeMed Vision Care directory.
- Call and make an appointment, identifying yourself as an EyeMed member.
- Pay your co-pays for your exam and prescription glasses (lenses and frame) or contacts if you are purchasing them.
- Pay for any discounted lens options, such as tints, coatings and progressive lenses not covered by the plan, and any amount exceeding the EyeMed frame allowance.
- When you are making your appointment with an EyeMed network provider your provider will confirm your eligibility prior to your appointment.

What is a co-pay?

Your co-pay is the flat fee you pay out of pocket each time you receive vision care or purchase eye wear, such as glasses or contacts. You may incur additional out-of-pocket costs beyond what is covered by the vision plan.

What the plan covers

The vision plan covers specific vision services and eye wear as described in this section. Your coverage varies depending on whether you see a network or a non-network provider.

What the plan covers (cont)

The vision plan covers one eye exam per year. Prescription glasses and contacts are covered by the vision plan as follows:

Lenses and frames

- One pair of frames is covered once every two years.
- Up to one pair of lenses is covered per year.
- Tints, coatings, progressive lenses and other lens options are not covered, but may be purchased at an additional discounted cost from your EyeMed network provider.

Contacts

- One pair of elective contacts is covered per year. However, if you choose to purchase elective contacts instead of glasses, you are not covered for glasses in the same year. Additionally, you are not eligible for frames until the second year following the year you receive coverage for your elective contacts. For example, if you choose contacts in 2014, frames will not be covered until 2016.
- One pair of medically necessary contacts is covered in full by the plan per year if required for certain medical conditions. Medical necessity is defined in the plan document for this benefit.

Your Reimbursement Account covers vision expenses

If you participate in a reimbursement account and pay any out-of-pocket vision expenses, you may be reimbursed for these expenses from your health care reimbursement account. Out-of-pocket expenses include co pays and items not covered by the vision plan. See the Reimbursement Accounts chapter for more information.

LASIK Surgery Discounts

EyeMed Vision Care includes comprehensive information on laser vision correction surgery, as well as giving you substantial savings on the procedure. EyeMed Vision Care Services has a nationwide network of refractive surgeons who specialize in the popular elective procedures of photo-refractive keratotomy (PRK) and LASIK. These providers offer EyeMed Vision Care Plan members a 15% discount off their usual and customary surgical fees for these procedures or a 5% discount off the promotional price. For a complete list of providers, please call 1-877-5LASER6.

Vision Plan

	In-Network	Out-Of-Network Reimbursement
Comprehensive Exam	$15 Copay	Up to $30
Standard Frames	$100 Allowance 20% off balance > $100	Up to $50
Standard Lenses		
• Single vision	$25 Copay	Up to $25
• Bifocal	$25 Copay	Up to $40
• Trifocal	$25 Copay	Up to $60
• Lenticular	$25 Copay	Up to $60
Contact Lenses (in lieu of spectacle lenses)		
• Medically Necessary	Covered in full	Up to $200
• Standard Lens (Fit & Follow-up)	Up to $40	Not Covered
• Premium Lens (Fit & Follow-up)	10% off retail	Not Covered
Frequency		
• Examination	12 Months	12 Months
• Lenses	12 Months	12 Months
• Frames	24 Months	24 Months
• Contact lenses	12 Months	12 Months
Discount on additional purchases		
• Complete pair of eyewear	40% off retail	Not Covered
• Non-prescription sunglasses	20% off retail	Not Covered
• Contact lenses	15% off retail	Not Covered
• Scratch coating	$15	Not Covered
• Polarized	20% off retail	Not Covered
• RK and LASIK	5-15% off retail	Not Covered

Coverage Level	Bi-Weekly Rates
Employee Only	University paid
Employee + Spouse	$1.36
Employee + Children	$1.51
Employee + Dependents	$2.94

What Is Not Covered

The vision plan does not cover vision services and eye wear if they are covered, in whole or in part, under any medical plan.

- Orthoptics or vision training and any associated supplemental testing
- Plano nonprescription lenses
- Two pairs of glasses instead of bifocals
- Replacement of lenses and frames paid for by the plan that were lost or broken
- Medical or surgical treatment of the eyes (except Lasik or PRK)
- Corrective vision services, treatments and materials of an experimental nature

How To File A Claim

Your EyeMed Vision Care network provider takes care of all the paperwork for you, so you do not need to file a claim if you visit someone in the EyeMed Vision Care network.

When you visit any non-EyeMed Vision Care provider, you must pay for services at the time you receive. EyeMed Vision Care does not use claim forms. However, employees need to complete the out-of-network claim form found in the EyeMed Vision Care Website and submit for out-of-network reimbursement including:

- The Policy number as found on the ID card.
- The employee's name and social security number.
- The dependent's name and social security number when the dependent has used the benefit.
- Original copy of the itemized paid receipts received from the provider describing the services and/or products provided, and the cost attributable to each item. This information should be mailed, faxed or emailed promptly to:

EyeMed Vision Care
Attn: OON Claims
PO BOX 8504
Mason, OH 45040-7111
Email: oonclaims@eyemed
FAX: 866-293-7373

Questions?

For answers to your questions about the vision plan, contact EyeMed Vision Care Customer Service at 866-9EYEMED (866-939-3633).

Flexible Spending Accounts

Flexible Spending Accounts allow employees to set aside before-tax dollars up to a defined limit. It provides employees with tax relief to pay for certain qualifying health care and dependent care costs not reimbursed by the health plans.

For the average employee, this equates to a 25% cost savings on qualified expenditures.

Health Care FSA (HCFSA)

If you have health care expenses not covered by your medical, dental or vision plan, pay for these expenses with before-tax dollars through the HCFSA, even if you are not enrolled in a medical plan.

Dependent Care FSA (DCFSA)

If you have dependent care expenses for your child(ren) under age or a disabled adult family member, enroll in the DCFSA and pay for these expenses with before-tax dollars.

AmeriFlex
888.868.3539

Flexible Spending Accounts

How The Plan Works

All full-time employees are eligible to participate in the flexible spending accounts. Once you establish eligibility, you can enroll in either the health care flexible spending account (HCFSAA), the dependent care flexible spending account (DCFSA), or both. The two plans are similar in how they work, but they are separate accounts and differ in some important ways.

If you enroll, Lynn University will automatically deduct your contributions from your paychecks before taxes are withheld and deposit them in your flexible spending account(s). You do not pay taxes on the money you put into the account or on the money taken out of the account in the form of reimbursements (including Social Security and Medicare [FICA] taxes, federal income tax). Because the dollars you contribute are not taxed, the IRS imposes limits on how those dollars may be reimbursed to you. For example, the IRS determines what is considered a qualifying expense, the last day you can file your claims and who is considered a qualifying dependent.

Evaluating the best tax advantage

Before you enroll in a flexible spending account, weigh the tax advantages. You may find that it is more tax advantageous for you to claim a deduction or credit on your federal income tax rather than use a flexible spending account. For example, if you have medical expenses totaling more than 7.5% of your adjusted gross income each year, you may be able to deduct them as medical expenses on your tax return. If you have dependent children, you may already be taking advantage of the federal child and dependent care tax credit.

To see whether flexible spending accounts make more sense for your personal tax situation, obtain a copy of the IRS publications 502 (Medical and Dental Expenses) and 503 (Child and Dependent Care Expenses) and talk with a tax advisor. These publications are available online at www.IRS.gov.

There are several tax considerations to keep in mind when deciding whether or not to participate in the flexible spending accounts:

- You cannot claim a tax deduction or take a tax credit for the same expenses that you have been reimbursed for through your flexible spending account.
- Tax credits and tax deductions reduce your income tax at the time you file your tax return. Flexible spending accounts reduce your income tax withholding throughout the year.
- Participating in a flexible spending account may reduce your Social Security benefits in the future.

Which method is best for you - flexible spending accounts, tax credits or deductions? It all depends on your personal tax situation. You may want to talk to a tax advisor before you make a decision.

Flexible Spending Accounts

Participating in the plans

Estimate the amount you will spend on qualifying health care and dependent care expenses in a plan year and determine if flexible spending accounts make more sense than using the medical expense deduction or child care tax credit. If you initially establish benefits eligibility in the middle of a plan year or you have a qualifying life event, remember to forecast your expenses and contributions over fewer pay periods. Your maximum contribution will be based on a per-pay-period maximum.

If you experience a qualifying life event during the year, such as adding a newborn or changing dependent care providers, you may be able to change your flexible spending account contributions.

Annual Open Enrollment

Each year, during the annual benefits open enrollment period, you have the opportunity to participate in the flexible spending accounts for the upcoming plan year. During this time, you can enroll for the first time, re-enroll or change the amount you are contributing. If you do nothing, your previous contribution election will automatically be reset to $0.

Even if you do not want to make any changes to the amount you are contributing, you must re-enroll each annual open enrollment period to continue participation.

Paying for qualified expenses

After enrollment, Ameriflex will issue you a debit-type MasterCard that allows you to pay for services from your account. You use the card to pay at the time of service, keeping your receipts. Each time you use the card, you may receive a request to substantiate your purchases with receipts. You must mail or fax a copy of your receipts to AmeriFlex. If purchases are not substantiated within 30 days, the card will be deactivated until receipts are submitted.

Important rules to remember:

Certain IRS rules apply to reimbursement accounts:

- All regular full-time employees are eligible; you do not have to be enrolled in a medical or dental plan to participate.
- Contributions are elected on an annual basis. Annual elections cannot be changed during the year unless you experience an IRS-defined change in status.
- Your annual election amount is eligible from January 1. Money can be taken out before it is put in.
- You must enroll each year in order to participate–you are not automatically enrolled each year.
- In order to be reimbursed from your account, the expenses you claim must be eligible under IRS regulations, incurred during the plan year (January 1 through March 15 of the following year), and submitted by the following March 31.
- If you wish to continue to participate (incurring eligible claims) while on leave without pay, you must make your regular contributions on an after-tax basis.

Health Care Flexible Spending Account (HCFSA)

If you have health care expenses not covered by your medical, dental or vision plan, you may be able to pay for these expenses with before-tax dollars through the HCRA. You can participate in the HCFSA even if you are not enrolled in a medical plan.

Each year, you can contribute up to $2,600 to an HCFSA. Only specific types of expenses can be reimbursed by your account and unused balances are forfeited at the end of the plan year.

What the account covers

You can be reimbursed for qualifying health care (medical, prescription drugs, dental, vision and prescribed over-the-counter drugs) costs for you, your children and your spouse - even if you or they are not covered by Lynn's health plans. Health care expenses for your domestic partner or same-sex spouse are reimbursable only if your domestic partner or same-sex spouse also qualifies as your dependent for federal tax purposes.

Qualifying health care expenses are those you have incurred that are not covered under any health plan you are enrolled in. They may include, but are not limited to:

- Deductibles, coinsurance amounts and co-pays for medical, prescription drug, dental and vision plans
- Over-the-counter drugs (with a doctor's prescription)*
- Artificial limbs and eyes
- Braille books and magazines for the visually impaired if they cost more than regular books
- Compact lenses and contact lens supplies
- Crutch purchase or rental
- Eye care and eyewear (excluding accessories)
- Unreimbursed hearing aid expenses
- Unreimbursed prescribed contraceptives (birth control pills, ete.)
- Special education for mentally impaired or physically disabled individuals
- Syringes, needles or other medical supplies
- Travel and lodging to receive medical care
- Unreimbursed orthodontia expenses

For specifics on what your HCRA will cover, visit www.flex125.com or visit www.irs.gov and search for IRS publication 502.

*Debit card may not be used to purchase prescribed over-the-counter drugs

Special rule for orthodontia

Typically, treatment for orthodontia ranges from a few months to several years. The IRS has recognized that orthodontia billing practices differ from other health care billing practices. One orthodontia invoice may include expenses for multiple visits, often well into the future. For this reason, the IRS allows you to submit orthodontia claims for reimbursement at the time you pay the invoice, even if all the treatment sessions have not yet occurred. However, the expenses on the invoice must be related to the current plan year (January 1 through March 15 of the following year).

What is not covered

Some expenses that cannot be reimbursed by the HCFSA include, but are not limited to:

- Expenses incurred before your enrollment begins or after it ends
- Expenses incurred while on an approved leave of absence, unless you have continued to make your contributions during your leave
- Health care coverage premiums
- Items covered under a plan you or your family is enrolled in at the time the expense is incurred
- Cosmetic surgery or services
- Health club membership dues
- Dietary supplements, including vitamins
- Special education for mentally impaired or physically disabled persons if the education is intended to relieve the disability
- Long-term care or insurance premiums
- Prescribed over-the-counter drugs

Reimbursement following an election change

If you change your HCFSA election midyear due to a qualifying life event, you will be reimbursed up to your annual contribution election in effect at the time your expenses were incurred. For example: You enrolled for the HCFSA and contribute $1,500 annually. You already filed claims and received reimbursement for the full $1,500 by February 1. Then, on April 20, you marry (a qualifying life event) and increase your annual HCFSA contribution amount from $1,500 to $2,000. You are now able to submit claims for reimbursement for up to $500 for services incurred from your enrollment date through the end of the plan year.

When coverage ends

If you are no longer a Lynn University employee, your payroll deductions for the HCFSA automatically end. You can submit claims against your remaining annual contribution election until the March 31 of the following year for claims incurred before your termination date.

You can continue your HCFSA coverage through COBRA. You may only continue coverage for your HCFSA through the end of the plan year if you have amounts remaining in your account as of the date of your termination. If your HCFSA is "overspent" (you have received reimbursements in excess of the amount that you have contributed), you cannot continue coverage.

If you choose to continue your HCFSA contributions through COBRA, your annual contribution amount remains the same and you can continue to submit claims and be reimbursed for services incurred during the period you are covered through COBRA. Your COBRA contributions will include a 2% administration fee and the contributions are on an after-tax basis.

Dependent Care Flexible Spending Account (DCFSA)

If you have dependent care expenses for your child(ren) under age 13 or a disabled adult family member, you can enroll in the DCFSA and pay for these expenses with before-tax dollars.

- Each year, you can contribute up to $5,000 per household per plan year to a DCFSA.

What the account covers

You can use the DCFSA to pay for dependent care costs that allow you - and your spouse, if you are married - to work outside of your home, attend school full time or look for work.

The dependent care services may be provided in your home or another location, but not by someone who is your child under age 19 or considered your dependent for income tax purposes. If the services are provided by a dependent care facility that cares for more than six people, it must be licensed and meet state and local regulations. Services must be for the physical care of your dependent(s), not for things like education, meals and so on.

You can use the account to pay for the dependent care costs of:

- Your dependent child(ren) under age 13 who must be your "qualifying child" tax dependent (as defined by the IRS) or - if there has been a divorce or other legal separation of the parents - you must be the custodial parent
- Your spouse, who is physically or mentally incapable of caring for himself or herself and spends at least eight hours a day in your home
- Any other person who is physically or mentally incapable of caring for himself or herself, spends at least eight hours a day in your home and is also your tax dependent or a child for whom you are the custodial parent

Eligible expenses include:

- Costs for a day care center, if the center complies with all state and local laws
- Tuition for nursery school, if the school complies with all state and local laws
- Costs for family or adult day care facilities
- Wages paid to a nanny or companion in or outside of your home

For more information on what your DCRA may reimburse, visit www.flex125.com or visit www.irs.gov and search for IRS publication 502.

Day Care rates

You may be able to change your contribution amount midyear if your day care costs change, for example, because you change day care providers, you experience a change in your day care provider's or nanny's rates, or the hours of care change.

Paying for services in advance

Many day care providers require payment in advance of providing services. This plan does not allow reimbursement for dependent care services until they have been incurred. So, if your dependent care provider bills in advance for future services, you will need to wait until that billing period has passed before you submit your claim. In these instances, you may want to request that your provider bill you more frequently in order to receive more timely reimbursements from the plan.

Child and dependent care tax credit

In some cases, you may get a better tax advantage with the federal child and dependent care tax credit than with the dependent care reimbursement account. See a tax advisor to find out which works best for your situation.

What is not covered

Your DCFSA will not reimburse:

- Wages for dependent care paid to someone whom you claim as a dependent on your federal income tax return
- Dependent care given during your (and your spouse's) unscheduled work hours
- Any school costs for a dependent of school age, including kindergarten and summer school services (if the cost of schooling cannot be separated from the child care aspect of the program, the entire cost may be eligible)
- Overnight camp
- Nursing home expenses for dependents who do not live with you
- Dependent care for a child age 13 or over, unless they are incapacitated

Questions?

For answers to your questions about reimbursement accounts, contact AmeriFlex at 888-868-3539 or visit www.myameriflex.com.

Short & Long-Term Disability

Short & long-term disability is available to Lynn University full time employees. Disability insurance policies pay 60% of your annual salary if you are unable to work due to illness or injury.

Disability

Disability coverage gives you the security of knowing that if you become disabled, replacement income is available to help you maintain your present lifestyle.

Unum
866.679.3054

Short-Term Disability

How the Plan Works

Lynn University's short-term disability (STD) benefits pay you directly after you have been disabled for a continuous 30-day period. It can replace part of your income if you are totally disabled and cannot work. You must be eligible on the date your disability commences as determined by Unum, the plan administrator, in order to receive STD benefits. If you are not actively working at Lynn University at the time you initially become benefits eligible - STD coverage will go into effect once you return to work at least one full day.

During the first 30 days of disability, called the "elimination period", you will be considered totally disabled if you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury and are under the regular care of a physician. STD coverage extends from day 31 through day 180. After day 180, long-term disability coverage would pay you, if elected.

What is a disability?

Due to accidental bodily injury, sickness, mental illness, substance abuse or pregnancy you are unable to perform the essential duties of your occupation, and as a result, you are earning less than 20% of your predisability weekly earnings or you are able to perform some, but not all, of the essential duties of your occupation and as a result, you are earning less than 80% of your pre-disability weekly earnings. You must be under the regular care of a physician to receive benefits.

Calculating your benefits

Your STD plan replaces 60% of your weekly earnings, up to a maximum benefit of $1,500 per week. Your benefit payments may be reduced by other income you receive or are eligible to receive, such as:

- Social Security Disability Insurance (please see next section for exceptions)
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (ie: pension plan)

Exclusions and Limitations

You cannot receive STD benefit payments for disabilities that are caused or contributed to by:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Sickness or injury for which Workers' Compensation benefits are paid, or may be paid, if duly claimed
- Any injury sustained as a result of doing any work for pay or profit for another employer

Long-Term Disability

How the Plan Works

Lynn University's long-term disability plan picks up where short-term disability (STD) leaves off after you have been disabled for a continuous 180-day period. It can replace part of your income if you are totally disabled and cannot work. You must be eligible on the date your disability commences as determined by Unum, the plan administrator, in order to receive LTD benefits. If you are not actively working at Lynn University at the time you initially become benefits eligible - LTD coverage will go into effect once you return to work at least one full day.

During the first 180 days of disability, called the "elimination period", you will be considered totally disabled if you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury and are under the regular care of a physician. The short-term disability plan may pay you benefits during the elimination period.

Definition of disability

Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical conditions covered by the insurance, and as a result, your current monthly earnings are 80% or less than your pre-disability earnings. Once you have been disabled for 24 months, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are 60% or less than your pre-disability earnings.

Calculating your benefits

Lynn University provides all regular, full time employees LTD coverage at no cost. This benefit pays you 60% of your earnings to a maximum monthly benefit of $10,000 per month. This plan includes a minimum benefit of the greater of:

- 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits; or
- $100 per month.

LTD benefits will continue for as long as you remain disabled, or until you reach your Social Security Normal Retirement Age, whichever is sooner. If your disability occurs at age 65 or above, your payments may be reduced.

Your benefit payments may be reduced by other income you receive or are eligible to receive, such as:

- Social Security Disability Insurance (please see next section for exceptions)
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (ie: pension plan)

When Your LTD Benefits Begin And End

Your LTD benefits begin when the elimination period ends (after 180 continuous days of a total medical disability) and after your LTD has been approved by Unum. Your LTD benefits will continue until one of the following occurs:

- You are no longer medically disabled under the terms of the plan.
- Your monthly disability earnings exceed 99% of your pre-disability earnings until partial disability benefits have been paid or 85% after partial disability monthly benefits have been paid.
- You reach the end of the maximum benefit period.
- You fail to provide proof of your continued medical disability, as requested by Unum.
- You pass away.

Maximum benefit period

How long you can receive benefits from the LTD plan depends on your age when you become totally medically disabled. When you reach the maximum benefit period, your LTD benefits will end.

If you are overpaid, Unum has the right to recover any overpayments resulting from errors Unum makes in processing a claim, your receipt of deductible sources of income and fraud. Unum will determine your repayment method.

If you have a recurrent disability

A recurrent disability is a disability which is caused by a worsening in your condition and due to the same cause(s) as your prior disability for which you received a monthly LTD benefit.

If you are receiving LTD benefits, recover and return to active employment in your regular occupation, then suffer a relapse, certain provisions apply.

Taxes and LTD

Your LTD payments may be subject to taxes, including federal and state income taxes, as well as unemployment taxes. You may want to talk to a tax advisor for more information.

Questions?

For general questions about the STD and LTD plans, how to file a claim or for the status of your ongoing claim payments, call Unum at 866-679-3054.

Exclusions and Limitations

You cannot receive LTD benefit payments for disabilities that are caused or contributed to by:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Sickness or injury for which Workers' Compensation benefits are paid, or may be paid, if duly claimed
- Any injury sustained as a result of doing any work for pay or profit for another employer

Pre-Existing conditions

In general, if you were diagnosed or received care for a condition before the effective date of your insurance, you will be covered for a disability due to that condition only if:

- You have not received treatment for your condition for the length of time specified in the contract before the effective date of your insurance;
- You have been insured under this Insurance for length of time specified in the contract before your disability starts, so you can receive benefits even if you're receiving treatment; or
- You have already satisfied the pre-existing condition requirement of your previous insurer.

Mental Illness, Alcoholism and Substance Abuse

You can receive benefit payments for long-term disabilities resulting from mental illness, alcoholism and substance abuse for a total of 24 months for all disability periods during your lifetime. Any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 24 months lifetime limit.

What is considered mental illness?

Mental illness is defined as a psychiatric or psychological condition regardless of cause, such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental heath provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment.

Self-reported symptoms are the manifestations of your condition, which you tell your physician, that are not verifiable using tests, procedures or clinical examinations generally accepted in the practice of medicine. Examples include, but are not limited to, headaches, pain, fatigue, stiffness, soreness, ringing in the ears, dizziness, numbness and loss of energy.

Exclusions and Limitations

You cannot receive LTD benefit payments for disabilities that are caused or contributed to by:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Sickness or injury for which Workers' Compensation benefits are paid, or may be paid, if duly claimed
- Any injury sustained as a result of doing any work for pay or profit for another employer

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In general, if you were diagnosed or received care for a condition before the effective date of your insurance, you will be covered for a disability due to that condition only if:

- You have not received treatment for your condition for the length of time specified in the contract before the effective date of your insurance;
- You have been insured under this Insurance for length of time specified in the contract before your disability starts, so you can receive benefits even if you're receiving treatment; or
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Self-reported symptoms are the manifestations of your condition, which you tell your physician, that are not verifiable using tests, procedures or clinical examinations generally accepted in the practice of medicine. Examples include, but are not limited to, headaches, pain, fatigue, stiffness, soreness, ringing in the ears, dizziness, numbness and loss of energy.

Life Insurance and AD&D

Having financial protection in the event of death means more security for your family members.

Lynn University provides you with free basic life insurance and AD&D coverage. You have the option to purchase supplemental coverage for you and your dependents.

Employee Life Insurance

Basic life and AD&D is provided by Lynn University at the lesser of $100,000 or one times your annual salary. You can extend your coverage up to the lesser of 5 times your annual salary or $500,000 by purchasing supplemental life insurance at an additional cost. Premiums are dependent upon the amount of coverage elected and your age.

Spouse and Child Life Insurance

You can purchase up to the lesser of 50% of self coverage or $250,000 of life insurance for your spouse and up to $10,000 for your dependent children.

Unum
866.679.3054

Life Insurance and AD&D

How The Plan Works

Employee life insurance provides benefits to your designated beneficiary(ies) if you die. The more others depend on you and your income, the more life insurance you may need. Your coverage level is the amount that is paid to your beneficiary(ies) if you die .

Lynn University gives you the option to purchase additional life insurance coverage for yourself, your spouse and domestic partner and your dependent child(dren). You may choose spouse/domestic partner and/or dependent life insurance only if you purchase additional coverage for yourself.

All three Lynn University life plans - employee, spouse/domestic partner and child - are insured by Unum.

Basic Life Insurance

You are automatically covered for employee life insurance coverage at one times your annualized base pay, paid for by Lynn University.

Supplemental Life

Supplemental life extends your basic life insurance coverage up to 5 times your annual salary in $1,000 increments. Your payroll deductions for coverage are taken after taxes are withheld.

Your coverage amount is based on your annualized base pay at that time, rounded up to the next highest $1,000. Your annualized base pay is your gross earnings prior to any deductions. It does not include any stipends, bonuses, overtime pay or other compensation. The maximum amount of supplemental life insurance coverage that you can purchase through Lynn University is the lesser of 5 times your annual salary or $500,000.

Rates are based on age and coverage amounts. As you age your deductions will remain the same until the next plan year. If your base pay changes during the year, any benefit paid to your beneficiary(ies) will be based on your actual pay at the time life insurance benefits become payable. You need to be actively at work at the time a pay change goes into effect for your life insurance coverage to reflect that change. Otherwise, the change will take effect when you actively return to work .

Beneficiary designation

You are asked to designate beneficiaries for coverage on your life insurance at the time you enroll in Lynn University benefits. Beneficiaries can be changed at any time during the year. The Beneficiary Designation Form can be found on MyLynn under the Personal Tab/Employee Benefits.

Reduction in benefits

The amount of your death benefit is reduced once you reach age 65. Any reduction in your death benefit may also reduce your spouse and child life insurance coverage amounts, if enrolled, in order to satisfy the rule that your dependent life insurance coverage cannot be more than 50% of your life insurance coverage.

Spouse/Domestic Partner Life Insurance

You can elect spouse/domestic partner coverage only if you are enrolled in employee life insurance. You can elect coverage in $1,000 increments up to $250,000 depending on the amount of your life insurance coverage. The amount of coverage you elect for your spouse/domestic partner cannot exceed 50% of your total life insurance coverage amount. You pay the full cost of spouse/domestic partner life insurance through automatic payroll deductions taken after taxes are withheld.

If your spouse/domestic partner is also an employee at Lynn University and is eligible for benefits coverage, you cannot cover him or her as a dependent under the life insurance plan.

Child Life Insurance

You can elect child life insurance only if you are enrolled in employee life insurance. You can elect child coverage of $10,000 per child only if you are enrolled in employee life insurance. The amount of child life insurance coverage you elect cannot exceed 50% of your total employee life insurance coverage amount. The cost for this coverage is the same regardless of the number of children you cover. You pay the full cost of child life insurance through automatic payroll deductions taken after taxes are withheld.

How Benefits Are Paid

Life insurance benefits are paid to your designated beneficiary(ies) if you die. Benefits are paid to you if your covered dependent dies.

Employee life insurance

When Unum receives notice of your death, the amount of life insurance benefit are paid to your named beneficiary(ies). Unum has the right to review and deny the claim if payment of the claim is forbidden by law. Unless you have given different instructions, your insurance benefit is paid as listed below:

- If more than one beneficiary is named, each is paid equal shares.
- If any named beneficiary dies before you, that person's share is divided equally among the named beneficiaries who survive you.
- If no beneficiary is named, or if no named beneficiary survives you, Unum may pay:
- The executors or administrators of your estate
- Your surviving relatives in the following order:
  - Your spouse
  - Your children in equal shares
  - Your parents in equal shares

Spouse/domestic partner or child life insurance

If your dependent dies while covered under Lynn's life insurance plan, you will receive his or her life insurance benefit. Unum has the right to review and deny the claim if your spouse or child failed to disclose important information about his or her health as described in "Evidence of Insurability" or if payment of the claim is forbidden by law.

Evidence of insurability

Evidence of insurability is proof of good health as certified by a licensed doctor and approved by Unum. You or your covered dependents may be required to provide Evidence insurability in certain instances for coverage under the life insurance plans. When asked, you will need to complete a form that provides information about your health and medical history, so that Unum may determine whether you quality for certain levels of coverage.

Accidental Death & Dismemberment (AD&D)

You are automatically covered for employee AD&D at 1x your annualized base pay, paid for by Lynn University.

Your AD&D insurance pays lump-sum benefits to you if you lose a limb, your hearing or your sight in a covered accident - or to your beneficiary(ies) if you die in a covered accident - if your loss occurs within 365 days after the date of the accident.

If you die as the result of a covered accident, your beneficiary(ies) will receive your AD&D benefit in addition to any group life insurance benefits. The maximum benefit payable is 100% of your AD&D coverage for all losses combined due to the same accident.

What is the difference?

AD&D pays benefits if you are injured or die in an accident, while employee life insurance pays benefits if you die, whatever the cause. If you die as a result of an accident, your beneficiary(ies) will receive benefits from both plans, if you were covered by both plans at the time of your death.

Seat belt coverage

If you die in an accident while riding or operating a registered automobile and while wearing a seat belt, the amount of the benefit payable for accidental death will be increased by 10% up to a maximum of $10,000. The accident must be unintentional and your use of a seat belt must be verified in the police report. Automobile includes a four-wheeled, private passenger car, station wagon, van, SUV or similar vehicle that is not being used as a common carrier for the transportation of passengers for hire.

The additional seat belt coverage will not apply if you were driving the vehicle while under the influence of drugs or alcohol or if the driver was driving without a valid drivers license or if driver was driving in excess of the legal speed limit.

Reduction in benefits

AD&D benefits for employees will terminate at age 80 or upon retirement, whichever occurs first. Prior to this, benefits reduce by: 65% at age 65; and 50% of the original amount at age 70. Spouse benefits reduce by 65% at Employee's age 65; and 50% of the original amount at age 70. Spouse benefits are cancelled at the employee's date of death.

What AD&D Does Not Cover

Lynn University's AD&D plan does not cover losses resulting from:

- An intentionally self-inflicted injury, a suicide or attempted suicide, whether sane or insane
- War or an act of war (declared or undeclared)
- An injury sustained while full time in the armed forces of any country or international authority
- An injury sustained while riding on any aircraft, except a civil or public aircraft (with a current and valid airworthiness certificate and piloted by a person with a valid and current pilot's license for the aircraft) or a military transport aircraft
- An injury sustained while committing or attempting to commit a felony
- An injury sustained while riding on any aircraft if you are a:
  - Pilot, crew member or student pilot
  - Flight instructor or examiner

If you are an active flight crew member employed by Lynn University and are enrolled in AD&D coverage, this exclusion will not apply to you while you are performing your job as a flight crew member.

When Employment Ends

You may continue the coverage life insurance and AD&D after your employment terminates, providing the coverage has been in force for at least 12 months and your employment is not terminating due to any sickness or injury or retirement. A written application must be made within 31 days of your termination. An additional billing fee will be applied depending on the payment method you select.

Conversion

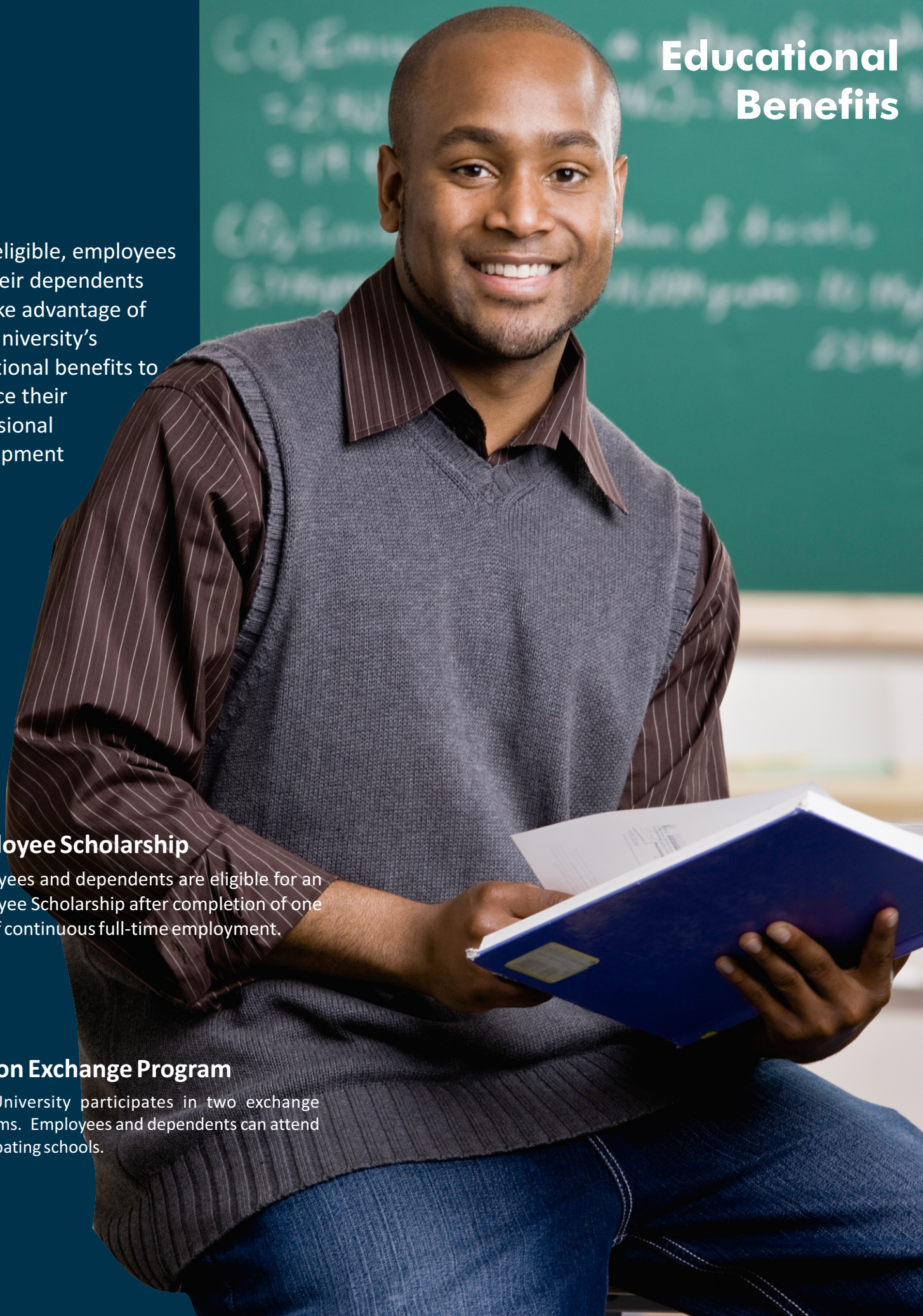
If you terminate your employment, or if you or your dependents become ineligible for life insurance and/or AD&D coverage for a reason other than nonpayment of premium or policy termination, then you will have the option to convert all or part of the terminated group Life Insurance to an individual life policy without Evidence of Insurability. Conversion election must be made within 31 days of your coverage termination.

Questions?

If you have general questions about the life insurance or AD&D plan or find out the status of an outstanding life insurance and/or AD&D claim, call Unum directly at 866-679-3054.

Educational Benefits

Once eligible, employees and their dependents can take advantage of Lynn University's educational benefits to advance their professional development



Employee Scholarship

Employees and dependents are eligible for an Employee Scholarship after completion of one year of continuous full-time employment.

Tuition Exchange Program

Lynn University participates in two exchange programs. Employees and dependents can attend participating schools.

Lynn Employee Scholarship

After one year of continuous full-time service, employees, children and spouses/domestic partners of full-time employees are eligible to enroll in the Lynn University day and evening undergraduate and graduate (masters only) courses, tuition-free, providing they do not interfere with schedule and work hours. All admissions are on a space available basis, and the employee, spouse/domestic partner or child must meet Lynn University's admission requirements.

Individuals taking advantage of this benefit must maintain at least a 2.0 cumulative GPA for undergraduate and 3.0 for graduate programs. Employees may not enroll in more than six (6) credits per term. The university reserves the right to revoke employee scholarship for any individual who exceeds two (2) unsuccessful attempts in the same course or if the GPA falls below the required minimum.

If eligible employees are laid off, go on a leave of absence, or have a status change from full-time to part-time, the employee scholarship will be retained for any approved academic term in progress. If eligible employees voluntarily or involuntarily terminate employment during an approved academic term, Lynn University reserves the right to revoke the employee scholarship.

To apply for the employee scholarship, employees must complete and submit the Employee Scholarship Form to Student Financial Services during the enrollment period of each semester or term. The financial FERPA form, Authorization of Credit form, and Financial Aid Institutional Application is required for all first-time enrollees. More information about the program, including copies of the forms, can be found on MyLynn.

Fees, book and registration

Fees must be paid at the time of registration by all employees and dependents. Employees and/or dependents must register in person. The employee scholarship benefit applies only towards tuition, not towards the purchase of books or equipment. An employee or dependent may apply for student loans to cover books, fees, equipment and/or expenses.

Study Abroad

The Employee Scholarship does not cover the cost of Study Abroad, however, any eligible employee or dependent that wishes to participate will be provided with a discount on the cost of the trip or the tuition.

Tuition Exchange Programs

Lynn University participates in two exchange programs: the Tuition Exchange, and the Council of Independent Colleges Tuition Exchange (CIC-TEP). Dependents of Lynn University full-time employees are eligible to apply.

Tuition Exchange Programs (cont)

CIC-TEP

The CIC is a network of colleges and universities willing to accept, tuition-free, students from families of full-time employees of other CIC participating institutions.

Eligible students are dependents (according to the IRS definition of a dependent), spouse/domestic partner, or full-time employees. Specifically, each participating institution in the CIC-TEP agrees to accept (import) a limited number of students from other colleges without regard to the number of students from other colleges, and without regard to the number of students it exports. Student applicants must be admissible at the host/importing institution in accordance with regular institutional admission standards and must comply with all of the host institution's financial aid policies and procedures. Applicants must maintain good academic standing and satisfactory academic progress.

Students are responsible for all non-tuition charges – room, board, and fees – at the institution in which they enroll (host/importing institution). Since there are no limitations on the total number of exports, this program may be used by any full-time employee at a participating institution. This approach is both nondiscriminatory and in full compliance with IRS regulations.
For more information, please visit www.cic.edu.

Tuition Exchange

Tuition Exchange is an association of over 500 colleges and universities offering scholarships to members of employees' families employed at participating institutions. It is important to work with the Tuition Exchange Liaison Officer in Student Financial Services. For more information, please visit their website at www.tuitionexchange.org.

Retirement Plan 403(b)

Lynn University's retirement plan offers you a variety of investment options, objective advice and planning services, and a dedicated website putting all your investment option information at your fingertips. These features are designed to make it easier than ever for you to manage your retirement investments.

TIAA-CREF
800.842.2776

Participation In The Plan

Participation in Lynn's retirement plan is voluntary and is designed to provide your with long-term financial security. All eligible faculty and staff may participate in the program immediately upon employment or at any time thereafter. After one year of continuous full-time employment, you are eligible for a 2% or 5 % contribution match, depending on your level of participation.

Flexible investment choices

TIAA-CREF offers investors a variety of vehicles to choose from with two distinct approaches.

One Decision – Take a "hands free" approach to managing your portfolio by choosing one of the TIAA-CREF Lifecycle Funds. These funds target your expected retirement date, from today through 2055 in five-year increments. All you need to do is select the fund closest to your estimated year of retirement. Each Lifecycle Fund starts with an asset allocation generally considered appropriate for investors at different stages of retirement planning. The funds readjust periodically to maintain an appropriate asset allocation for the remaining time horizon.

- Build Your Own Portfolio – For the more "hands on" investor, tailor your long-term portfolio by choosing from your menu of TIAA-CREF investment choices.

Please keep in mind that there are risks when investing in any mutual fund, including Lifecycle Funds. Please review the prospectus before investing.

A dedicated website

Once enrolled in a plan, you have secured personalized access to the TIAA-CREF website (www.tiaa-cref.org), where you can update your account, monitor account performance and sign up for e-delivery of account statements, transaction confirmations and other communications.

Advice and Planning Services

Personalized, objective advice and planning services is available to you for developing a plan to pursue your retirement income goal, or to find out if your current retirement planning strategy is on the right track.

One on one advice

To help you plan effectively for retirement, TIAA-CREF offers you access to skilled, non-commssioned TIAA-CREF consultants.

Highlights of the service include:

- Personalized Portfolio Recommendations, proposing specific mutual funds and annuity accounts considering every retirement plan option on TIAA-CREF's recordkeeping systems.

Additional Benefits

- Personal Health Advocate
- Supplemental Insurance:
  - Accident
  - Critical Illness
  - Supplemental Health
- Legal Plan
- Employee Assistance Program
- Group Auto Insurance
- Pet Insurance
- Pet Discount Plan

One on one advice (cont)

- Guidance on Past Plans, suggesting portfolios of broad asset lasses on any assets in previous employers' retirement plans on TIAA-CREF's recordkeeping systems.
- A Retirement Strategy Review that can take into account the full range of your retirement assets, and present models that assess the likelihood of reaching income goals. The service also recommends a savings level that may be appropriate for a particular goal. The financial and economic assumptions underlying the projections are based on historical rates of return that may not reoccur, as well as volatility measures and other factors.

The advice is provided in one-on-one sessions, in person or on the phone, to ensure the highest level of service and immediate attention to client needs.

Questions?

With these investment choices, tools, and other features, you should find it easy to customize a retirement portfolio that suits your unique needs. If you have any questions, log on to www.tiaa-cref.org or call TIAA-CREF at 800-842-2776.

Personal Health Advocate

Health Advocate, Inc., the nation's leading healthcare advocacy and assistance company, serves millions of Americans nationwide through its more than 4,100 client relationships. Health Advocate helps members navigate the healthcare system through a full spectrum of time- and money-saving solutions.

A personal health advocate is a trained professional who understands the healthcare system and will provide personal assistance in navigating through it. Some health advocate services include:

- Explain tests, treatments, medications & medical conditions
- Facilitate transfer of medical records, x-rays and lab results
- Arrange for diagnostic tests, home-care equipment, hospice care or participation in clinical trials
- Claims resolution

For more information, contact the Health Advocate at 866-695-8622 or www.healthadvocate.com.

Supplemental Insurance

The following Allstate supplemental insurances are elective and are available to all employees:

- **Group Accident Insurance** – benefit paid when expenses incurred are associated with an accidental injury. Expenses include treatment for on and off the job accidental injury.
- **Group Critical Illness** – benefit paid in lump sum to assist with out-of-pocket expenses associated with a critical illness. Critical illnesses include heart attack, heart transplant, stroke, coronary artery bypass surgery, paralysis, invasive cancer in addition to other illnesses.
- **Supplemental Health Insurance** - helps cover the expenses associated with a hospital stay or ambulance transportation. It pays you directly, unless you assign benefits, regardless of any other insurance you may have.

Additional information regarding Allstate Supplemental Insurance is available on the web at www.allstatebenefits.com.

Legal Plan

The university has partnered with Preferred Legal Plan™ ("PLP"), a licensed legal expense organization that provides its members with full service and representation on all types of legal services, including divorce, traffic tickets, buying or selling a home, bankruptcy, wills, probate, DUI, immigration, credit report issues, child support, custody and visitation, garnishments, defense of collections, foreclosures, criminal defense, lawsuits, small claims court, personal injury, landlord-tenant disputes, domestic violence and more.

- Plan offers 40% to 70% reduced legal fees for attorney representation on all types of legal services.
- 24 hours a day, 7 days a week access.
- Spouse/domestic partner, dependent children and entire household are covered.
- All communications are strictly confidential.
- Identity theft protection, Protect My ID, can be purchased separately or in addition to legal services.

Additional information regarding the Preferred Legal plan can be found on the web: www.preferredlegal.com.

Employee Assistance Program

There are times when we all need a little help. No matter what the issue, the Employee Assistance program through Unum is available 24 hours a day, 7 days a week with confidential support, guidance, and resources.

- Assistance for you or an immediate household family member
- Up to three in-person counseling sessions
- 24 x 7 x 365 telephone and web access
- Telephone access to legal counsel
- Work/life services for assistance with:
    - Parenting and childcare
    - Eldercare
    - Relationships
    - Work and career
    - Financial

To learn more about the Unum Employee Assistance program visit www.lifebalance.net (user ID and password = lifebalance) or speak with a specialist at 800-854-1446.

Group Auto Insurance

Group car insurance can be elected through Liberty Mutual insurance. This is a group benefit which offers savings and discounted rates on auto insurance through the Liberty Mutual Group Savings Plus Program. Support, claims assistance and information are all provided through Liberty Mutual. Benefits include:

- 10% discount on auto policies
- 24 hour emergency road side assistance
- Rates are guaranteed for 12 months, not 6
- Direct bill to your home or electronic funds transfer

Additional information about Liberty Mutual can be found at www.libertymutual.com.

Pet Insurance Plan

VPI Pet Insurance offers benefits to help keep your pet healthy. There are two levels of coverage to choose from with VPI Major Medical Plan having a higher level of the reimbursement and VPI Medical having a moderate level of reimbursement.

- Premiums vary based on the age, species and size of pet
- Use any veterinarian including specialists and emergency providers
- Benefits renew in full each year
- No lifetime limits
- No-deductible protection can be added

To learn more about VPI Pet Insurance visit www.petsVPI.com or call 877-PETS-VPI.

PETplus

For 2017 Pet Assure is offering an additional pet Rx/wellness plan at an introductory deduction rate.

Wholesale pricing membership on dog and cat health products:

- Prescriptions
- Preventives like flea, tick & heartworm
- Dietary Foods

Pickup at a local CareMark pharmacy, including CVS, Walmart, and Target.
Free delivaery on mail-orders.

Pet Discount Plan

Save on veterinary care with the Pet Assure Advantage discount plan. Pet Assure Advantage is not an insurance but rather a discount program designed to lower your veterinary costs. The discount program must be used with participating veterinarians.

How it works:
- Find a participating provider
- Present your membership card at any network veterinarian
- Receive a 25% discount on in-house medical services

Discounted services include:
- Office visits
- Shots
- X-Rays
- Surgical procedures
- Dental care

For a list of participating providers, go to www.petassure.com or call 877-FIND-VET (877-346-3838).

Life Planning Financial & Legal Resources

Life planning, financial and legal resource services are provided to all Group Life policyholders to assist with life transitions (i.e. when a loved one is terminally ill or passes away). These services are provided at no additional cost and are designed to provide financial and legal support regarding:
- estate settlement
- social security
- cash flow
- taxes
- investment planning

To speak to a counselor or for more information, call 800-422-5142 or visit www.lifeworks.com (id=unum; password=support).

Worldwide Travel Assistance

Worldwide travel assistance services are available to you when traveling for business or pleasure. Whether traveling to a foreign country or within the U.S., this coverage, which is provided by the University at no cost to you, provides you with access to emergency travel assistance resources for you and your family. The coverage includes:
- hospital admission coordination
- emergency medical evacuation
- medically supervised transportation home
- legal and interpreter referrals
- prescription replacement assistance
- multilingual crisis management professionals
- medical referrals to Western-trained, English-speaking medical providers
- care and transport of unattended minor children

For travel assistance or to learn more about this benefit, call 800-872-1414 (within the U.S.) or +(U.S. access code)609-986-1234 or email medservices@assistamerica.com; reference# 01-AA-UN-762490.