University of Louisville
VSIP Participant Benefit Transition Guide
2014
Thank you for your service to The University of Louisville and congratulations on your retirement! This comprehensive guide is designed to give you the information you need for a smooth benefit transition.

**Health Insurance**

If you are under age 65 you can continue participating in the University’s group health plan until you become Medicare eligible. Anthem BlueCross BlueShield is the university’s health plan administrator.

As part of the VSIP incentive the University will pay up to 50% of the health plan subsidy that applies to regular full-time employees for up to three years or until the employee becomes Medicare eligible (whichever occurs first). After three years, if the retiree is still not Medicare eligible, the University subsidy would be the regular retiree subsidy of $108.10 for the employee and another $108.10 if the spouse is covered in the active retiree plan. After retirees become eligible for Medicare, they will receive a stipend of $108.10 per month for themselves and an additional $108.10 per month for a spouse or partner toward the purchase of a Medicare supplement insurance policy purchased through AARP.

**2014 Monthly Rates for VSIP Retirees Under Age 65**

If you participate in Get Healthy Now, you will receive a “premium incentive” of $40 per month. The rates below do not reflect the $40 reduction.

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
<th>Cardinal Care</th>
<th>EPO</th>
<th>PCA High</th>
<th>PCA Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$334.96</td>
<td>$367.15</td>
<td>$353.24</td>
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<tr>
<td>Individual &amp; Spouse</td>
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<td>Family</td>
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<td>TYPE OF SERVICE</td>
<td>Network (Limited to UofL Hospital, MDs and UofL Physicians)</td>
<td>Out-of-network (Limited Only to Anthem Blue Access PPO Network)</td>
<td>Network (Limited to Anthem Blue Access PPO Network)</td>
<td>Out-of-network (Limited to Anthem Blue Access PPO Network)</td>
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<tr>
<td>Annual Allowance</td>
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<td>Does not apply</td>
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<td>Does not apply</td>
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<tr>
<td>Annual Deductible</td>
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<td>Annual Out-of-pocket Maximum</td>
<td>$2,000 per person</td>
<td>$4,000 per person</td>
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<td>$2,250 per person</td>
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<td>Physician office (OB/GYN visits originated on Primary Care Physician)</td>
<td>$35 Specialist, UofL, Physicians</td>
<td>$35 Specialist, UofL, Physicians</td>
<td>Not Covered</td>
<td>$35 Specialist, UofL, Physicians</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Preventive Care

- **Routine physicals, Well-child check-ups and routine immunizations:**
  - 100% Plan pays 100%
  - 60% after deductible
  - 100% Not covered
  - 100% 60% after deductible
  - 100% 60% after deductible
  - 100% 50% after deductible

- **Mammography screenings, Routine GYN exams:**
  - 100% Plan pays 100%
  - 60% after deductible
  - 100% Not covered
  - 100% 60% after deductible
  - 100% 50% after deductible

- **Lab, X-ray or other preventive tests:**
  - 100% Plan pays 100%
  - 60% after deductible
  - 100% Not covered
  - 100% 60% after deductible
  - 100% 50% after deductible

### Inpatient Hospital

- **Inpatient care:**
  - 100% Plan pays 100%
  - 90% after deductible
  - 60% after deductible
  - 90% after deductible
  - 60% after deductible
  - 80% after deductible

- **Physician Inpatient care:**
  - 100% UofL, Hospital only
  - 60% after deductible
  - 60% after deductible
  - 60% after deductible
  - 80% after deductible
  - 50% after deductible
### 2014 Plan Designs (continued)

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
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</tr>
<tr>
<td>Outpatient surgery - facility</td>
<td>100% after $50 copay</td>
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<td>Not Covered</td>
<td>90% after deductible</td>
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<td>Lab Services</td>
<td>100%</td>
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</tr>
<tr>
<td>X-Ray and Major Diagnostics</td>
<td>100%</td>
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<td><strong>Emergency Room</strong></td>
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<tr>
<td>Vision</td>
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<tr>
<td>Vision Exam (one routine exam per year)</td>
<td>100% after $75 copay</td>
<td>100% after $75 copay</td>
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<tr>
<td><strong>Mental Health &amp; Substance Abuse</strong></td>
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<tr>
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<td>100% after $500 copay per inpatient stay - Us, Hospital only</td>
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<tr>
<td>Outpatient care - per visit</td>
<td>$35 copay</td>
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**Condition Management Programs**
If you are under 65 and are enrolled in the University’s group health plan, you can participate in our Condition Management Programs.

**Diabetes Management Program**
The university offers this program to empower individuals to take charge of diabetes through medication therapy management with a pharmacist, and diabetes education with a Certified Diabetes Educator. In fact, participation in this program qualifies you to receive your diabetes, hypertension, and cholesterol medications for FREE!

Here are the basics:
- To enroll, call 502.562.4009 to make a one-hour appointment for preliminary blood work and diabetes management assessment.
- Once you are enrolled as an active member in the program, all hypertension, cholesterol, oral and injectable diabetes-related medications, insulin, and supplies are provided at no cost to you.
- Diabetes self-management classes taught by a Certified Diabetes Educator will help you learn to avoid complications and live the healthiest life possible!

Don’t pay for another round of medications or miss the opportunity to learn everything you need to know to manage your diabetes. Call 502.562.4009 today to get started!

**COPD Disease Management Program**
Are you experiencing symptoms of chronic cough, shortness of breath, fatigue, trouble catching your breath, repeated respiratory infections or wheezing? If so, you may be at risk for COPD and don’t want to miss the opportunity to participate in this remarkable condition management program.

UofL COPD Program includes:
- 2-hour assessment with a UofL Pulmonary doctor that includes a chest X-ray and lung function testing.
- Working with a respiratory therapist who will coach and empower you to proactively manage your health.
- **Free pulmonary prescription medications** for program participants.

Get started today: Call **502.852.2909** to learn more and schedule your appointment.
Post-65 Health Benefits

Once a retiree is within 3 months of reaching age 65, the retiree needs to contact the Benefits Department at 502.852.3167 to request an AARP Medicare Supplement Insurance Packet. All plans through AARP are presently insured by United Healthcare Insurance Company and United Healthcare Insurance Company New York for NY residents and are available through the AARP Health Care Options Program in the state of residence. This is a supplement toward the Medicare Part B to cover some of the cost that Medicare Part B does not cover. U of L pays $108.10 monthly ($216.20 if the retiree has a spouse to be covered). The retiree is responsible for any amount above the subsidy U of L provides toward the plan of choice and would be billed directly by AARP. If your plan is less than the subsidy amount then this amount is retained by the university. Your benefits counselor will order an application and a booklet containing all the information you will need to make an informed decision. The plan costs in the booklet you will receive from AARP does not include the deduction of our $108.10 subsidy amount.

Medicare Part D-Prescription Drug Program began January 1, 2006. Medicare prescription drug plans are available to individuals with Medicare. Private insurance companies will work with Medicare to offer these drug plans. U of L does not pay a subsidy toward your Medicare Part D.

Like other insurance, if you enroll in a prescription drug plan you will pay a monthly premium and pay a share of the cost of your prescriptions. Costs will vary depending on the drug plan you choose. Drug plans may vary in what prescription drugs are covered, how much you have to pay, and which pharmacies you can use. All drug plans will have to provide at least a standard level of coverage, which Medicare will set. However, some plans might offer more coverage and additional drugs for a higher monthly premium. When you join a drug plan, it is important for you to choose one that meets your prescription needs. You may wish to contact your pharmacist for assistance in choosing a drug plan that will best meet your needs.
For Questions About the AARP Medicare Supplement

To find out more about the AARP Medicare Supplement Insurance plans, visit www.aarphealthcare.com and select the Medicare Supplement Insurance link or call the AARP Health Care Options Program at: 1.800.392.7537. Once you enroll, you may also use this link to access your account and receive other valuable information.

To find out more about Medicare (Part D) prescription drug plan, visit www.medicare.gov or call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

For specific questions about Social Security, please contact the Louisville Social Security Administration Office at 1.800.772.1213 or 502.582.6690. Additional contact information and directions on how to apply for social security benefit online may be found at www.ssa.gov.

You may also visit the local Social Security Administration Office at the following address:
  
  Social Security Administration Office  
  Room 101-601 W. Broadway  
  Louisville, KY 40202
Dental Insurance

You may continue your dental coverage, if you have coverage on the last payroll before your separation date. You may also enroll for the first time, make changes or drop your dental or vision insurance during any future open enrollment period.

Humana Dental 200 Plan

You may visit any dentist under the Humana dental plan but will save money and receive greater benefits when you go to a dentist in the Humana Dental PPO Network. Dentists outside the network can bill you for the charges above the amount covered by the Humana Dental plan.

- For a list of dentists in the Humana Dental network go to www.humana.com or for more information call 1.800.558.4444.

Dental rates for retirees and surviving spouses:

- Individual $23.25/month
- Individual & Spouse $46.47/month
- Individual & Children $54.86/month
- Family $84.84/month
## Humana Dental PPO 09

### University of Louisville

#### KENTUCKY

<table>
<thead>
<tr>
<th>Services</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar-year deductible</strong></td>
<td>Individual</td>
<td>$25</td>
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<tr>
<td>(excludes orthodontia services)</td>
<td>Family</td>
<td>$75</td>
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<tr>
<td><strong>Annual maximum</strong></td>
<td>Individual</td>
<td>$25</td>
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<td>(excludes orthodontia services)</td>
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<tr>
<td><strong>Preventive services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral examinations</td>
<td>100% no deductible</td>
<td>75% no deductible of in-network fee schedule</td>
</tr>
<tr>
<td>• X-rays</td>
<td></td>
<td></td>
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<tr>
<td>• Cleanings</td>
<td></td>
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<tr>
<td>• Topical fluoride treatment</td>
<td></td>
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<tr>
<td>• Space maintainers</td>
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<tr>
<td>• Sealants</td>
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<tr>
<td><strong>Basic services</strong></td>
<td>80% after deductible</td>
<td>60% after deductible of in-network fee schedule</td>
</tr>
<tr>
<td>• Emergency care for pain relief</td>
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<tr>
<td>• Basic oral surgery services - basic</td>
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<td></td>
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<tr>
<td>• Extractions of erupted tooth or root</td>
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<tr>
<td>• Fillings (amalgam, composite for anterior teeth)</td>
<td></td>
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<tr>
<td>• Prefabricated stainless steel crowns</td>
<td></td>
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<tr>
<td>• Periodontics</td>
<td></td>
<td></td>
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<tr>
<td>• Endodontics (root canal)</td>
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<td>• Complex surgical extractions - surgical</td>
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<td>• Removal of erupted tooth, impacted tooth, and tooth roots</td>
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<td><strong>Major services</strong></td>
<td>60% after deductible</td>
<td>40% after deductible of in-network fee schedule</td>
</tr>
<tr>
<td>• Crowns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inlays and onlays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bridgework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Denture relines and rebases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Denture repair and adjustments</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child orthodontia - Covers children through age 26</td>
<td>50% Plan pays (no deductible) of the covered orthodontia services, up to $1,000 lifetime orthodontia maximum</td>
<td></td>
</tr>
</tbody>
</table>

Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist.

1-800-233-4013 • Humana.com
Feel good about choosing a HumanaDental plan

Make regular dental visits a priority
Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke. Your HumanaDental PPO plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal.

* www.perio.org

Go to MyDentalIQ.com
Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth
• Use a soft-bristled toothbrush
• Choose toothpaste with fluoride
• Brush for at least two minutes twice a day
• Floss daily
• Watch for signs of periodontal disease such as red, swollen, or tender gums
• Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success? HumanaDental helps you feel good about your dental health so you can smile confidently.

* American Academy of Cosmetic Dentistry

Use your HumanaDental benefits

Find a dentist
With HumanaDental’s PPO plan, you can see any dentist. You save an average of 28 percent when you visit a dentist in HumanaDental’s PPO Network. To find a dentist in HumanaDental’s PPO Network, log on to Humana.com or call 1-800-233-4013.

Know what your plan covers
The other side of this page provides a summary of HumanaDental benefits. Your plan certificate describes in detail your HumanaDental benefits. You can find it on MyHumana, your personal page at Humana.com or call 1-800-233-4013.

See your dentist
Your HumanaDental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don’t have your card, you can print proof of coverage at Humana.com.

Learn what your plan paid
After HumanaDental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at Humana.com or by calling 1-800-233-4013.
Vision Insurance

You may continue your vision coverage, if you have coverage on the last payroll before your separation date. You may also enroll for the first time, make changes or drop your vision insurance during any future open enrollment period.

National Vision Administrator

National Vision Administrator’s broad national network consists of more than 44,000 providers and provider locations. Members may access optometrists and Ophthalmologists, as well as the convenience of retail locations. Participants may access the provider directory at www.e-nva.com.

If you need additional information or assistance call National Vision Administrator Customer Service at 1.800.672.7723.

Vision rates for retirees and surviving spouses:

<table>
<thead>
<tr>
<th>Category</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$4.28/month</td>
</tr>
<tr>
<td>Individual &amp; Spouse</td>
<td>$7.76/month</td>
</tr>
<tr>
<td>Individual &amp; Children</td>
<td>$8.23/month</td>
</tr>
<tr>
<td>Family</td>
<td>$11.81/month</td>
</tr>
</tbody>
</table>
### Schedule of Vision Benefits

<table>
<thead>
<tr>
<th>Co-payment</th>
<th>Participating Provider</th>
<th>Reimbursed Amount</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10 Exam / $20 Lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td>Once Every Calendar Year</td>
<td>Covered 100%</td>
<td>Upto $50</td>
</tr>
<tr>
<td>Lenses</td>
<td></td>
<td>After $50 cap.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Once Every Calendar Year</td>
<td>Covered 100%</td>
<td>Upto $50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After $50 cap.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Standard Glass or Plastic</td>
<td>Covered 100%</td>
<td>Upto $50</td>
</tr>
<tr>
<td>Frame</td>
<td>Once Every Two Calendar Years</td>
<td>Retail Allowance</td>
<td>Upto $50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Up to $510 (20% discount off balance)**</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Once Every Calendar Year</td>
<td>Elastics Contact Lenses</td>
<td>Upto $505</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medically Necessary***</td>
<td>Covered 100%</td>
<td>Upto $5210</td>
</tr>
</tbody>
</table>

*Does not apply to Wal-Mart / Sam's Club locations
**Does not apply to Wal-Mart / Sam's Club or Contact Fill locations
***Pre-approval from NVA required

Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- 500 Gold Tint
- 512 Fashion / Gradient Tint
- 515 Standard Scratch-Resistant Coating
- 517 Transitions Single Vision Standard
- 518 Transitions Multi-Focal Standard
- 520 Ultraviolet Coating
- 525 Polycarbonate (Single Vision 1.5 & over)
- 540 Standard Anti-Reflective
- 530 Glass Photogrey (Single Vision)
- 530 Glass Photogrey (Multi-Focal 19/0.0 over 20/0.0)
- 530 Glass Photogrey (Multi-Focal)
- 535 High Index
- 575 Polarized

Options not listed will be priced by NVA providers at their reasonable & customary retail price less 20%

Wal-Mart / Sam's Club Stores: Due to their everyday low prices Wal-Mart / Sam's Club will not provide the lens options at the fixed option pricing list. Wal-Mart / Sam's Club stores accept NVA for materials. Doctors affiliated with Wal-Mart / Sam's Club are not Wal-Mart / Sam's Club employees, therefore participation for exams varies.

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### National Vision Administrators, L.L.C.

#### Summary of Vision Care Benefits

National Vision Administrators, L.L.C. (NVA) has been contracted by your group to offer a comprehensive vision care plan to you and your eligible family members. Founded in January of 1979, NVA manages vision benefit services for approximately seven million lives nationwide. Group Effective 01/01/2012

#### How Your Vision Care Program Works

- **For your convenience**, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back.
- **When scheduling your appointment**, please notify the NVA participating provider of your choice that your vision coverage is administered by NVA.
- **The provider** will contact NVA to verify eligibility.
- **At the time of your appointment**, simply present your NVA identification card to the provider or indicate clearly that your benefit is administered by NVA.
- A vision claim form is not required at an NVA participating provider.
- **The provider** will inform you of your eligibility status prior to rendering services.
- **Be sure to inform the provider of your medical history and any prescription or over-the-counter medications you may be taking**

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at [www.e-nva.com](http://www.e-nva.com) or contact NVA’s Customer Service Department toll-free at 1.800.672.7723.

#### Eligibility

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses once every calendar year and a frame once every two calendar years and contact lenses once every calendar year.

#### Customer Service

To verify eligibility, locate a participating provider and receive answers to all your vision care related inquiries, please call NVA’s Customer Service Department toll-free at 1.800.672.7723 (TDD 877.677.3698).

- NVA’s Interactive Voice Response (IVR) system is available twenty-four (24) hours per day, seven (7) days per week. The IVR allows you to locate a participating provider in your area, check eligibility as well as the status of your claim(s).
- An NVA Customer Service Representative can be contacted twenty-four (24) hours per day, seven (7) days per week.

---

National Vision Administrators, L.L.C. • PO Box 2187 • Clifton, NJ 07015
Web: [www.e-nva.com](http://www.e-nva.com) • Toll-Free: 1.800.672.7723

This document has been printed on recycled paper.
Benefits at Participating Providers:
- The option of receiving services in- or out-of-network
- Extensive national provider network
- Enhanced in-network benefits:
  - 100% covered vision examination (after copy if applicable)
  - 100% covered standard spectacles (after copy if applicable)
  - Frame allowance covers thousands of fashionable frames in full
  - Allowance towards the cost of contact lenses and fitting fees
  - No claim forms: providers will submit claims directly to NVA.

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (measure of vision), refraction, tonometry (glaucoma test) and dilatation. Comprehensive eye examinations can aid in the early detection of ocular diseases and other serious medical conditions, diabetes and cardiovascular disease for example.

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office.

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses may be covered with prior authorization when prescribed for post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Discounts: In addition to your funded benefit, you are eligible to access the EyeEssentials™ Plan discount on additional purchases during the plan period.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost of the time of service at a non-participating provider. To obtain direct reimbursement according to your plan design, you can print a claim form from the NVA website. Please complete this form and submit along with an original or copy of the itemized receipt. If you cannot complete the claim form, you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA's Clifton, NJ office. Remember, obtaining vision care services from a non-participating provider will result in greater out-of-pocket expenses.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pairs of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses / contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage.

Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Valuable Member Discounts
Laser Eye Surgery: NVA has chosen The National LASIK Network to serve their members. This network was developed by LCA Vision in 1998 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

All providers are contracted to extend members discounts on standard prices or promotional prices, ensuring the member will pay less than the public.
- 15% off standard prices - or - 5% off promotional pricing

All-Inclusive Discount
- All in network providers extend the discount on the entire cost of the procedure, maximizing member savings.

Additional Member Value – Members are entitled to these additional benefits available exclusively at select providers (over 90 locations nationwide).
- Special “set prices” ranging from $950 to $1,995 per eye on select technologies.
- Free initial consultation and comprehensive LASIK exam
- Advanced laser technologies including Wavefront and Intralase (All-Laser LASIK)
- Attractive financing options available

The process is simple:
- Find a provider (Call 1-877-286-8590 or visit www.e-nva.com)
- Schedule a pre-operative exam to determine if laser vision correction is right for you
- Schedule a treatment
- Pay discounted member price directly to the provider

Contact Fill: NVA provides you with the convenience and savings of CONTACT Fill, our mail order contact lens replacement service. You may access CONTACT Fill's services online at www.contactfill.com or by calling them toll-free at 866-204-1993. CONTACT Fill provides contact lens wearers with significant savings packaged with the convenience of home delivery. Plan discounts applicable at participating retail locations do not apply to purchases made through CONTACT Fill due to the already low prices.

Please enter NVAAX5NEW for free shipping and handling on your first order. Expires 12-31-13

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants.
- Locate a nearby participating provider by name, zip code, or City/State
- Verify eligibility for you or a dependent
- View benefit program and specific details
- Review claims
- Print ID cards (when allowable)
- Locate a non-participating provider to join the NVA network

If you are not a registered subscriber, you can still search our providers online by selecting the “Find a Provider” link on our homepage. Enter group number 517516002001 or the group number on the identification card you will be receiving prior to your effective date and enter in your search parameters. It's that easy!
Flexible Spending Accounts

If you are currently enrolled in a Health Care or Dependent Care Flexible Spending Account, all expenses must be incurred and your FSA will terminate on the last day of the month in which you work. You will then have 90 days to submit claims to Chard Snyder for reimbursement.

Term Life Insurance

As a retiree you have the option to purchase life insurance at the rates below:

For the first $5,000 of coverage the rate is $15 per year for 2014 (this cost is subject to change each year). If you purchase additional coverage, the premiums are based on your age and the amount of coverage you choose.

Up to $10,000 of life insurance is a guaranteed issue. If you choose an amount over $10,000 you must complete the Statement of Health Form.

<table>
<thead>
<tr>
<th>Age</th>
<th>$1000/Mo</th>
<th>$5,000/Mo</th>
<th>$5,000/Yr</th>
<th>$10,000/Yr</th>
<th>$15,000/Yr</th>
<th>$20,000/Yr</th>
<th>$25,000/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 – 54</td>
<td>$0.25</td>
<td>$1.25</td>
<td>$15.00</td>
<td>$30.00</td>
<td>$45.00</td>
<td>$60.00</td>
<td>$75.00</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$0.47</td>
<td>$2.34</td>
<td>$28.02</td>
<td>$56.04</td>
<td>$84.06</td>
<td>$112.08</td>
<td>$140.10</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$0.72</td>
<td>$3.59</td>
<td>$43.02</td>
<td>$86.04</td>
<td>$129.06</td>
<td>$172.08</td>
<td>$215.10</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$1.38</td>
<td>$6.90</td>
<td>$82.74</td>
<td>$165.48</td>
<td>$248.22</td>
<td>$330.96</td>
<td>$413.70</td>
</tr>
<tr>
<td>70 - 74</td>
<td>$2.24</td>
<td>$11.19</td>
<td>$134.22</td>
<td>$268.44</td>
<td>$402.66</td>
<td>$536.88</td>
<td>$671.10</td>
</tr>
<tr>
<td>75 - 79</td>
<td>$3.62</td>
<td>$18.12</td>
<td>$217.44</td>
<td>$434.88</td>
<td>$652.32</td>
<td>$869.76</td>
<td>$1,087.20</td>
</tr>
<tr>
<td>80 - 84</td>
<td>$5.87</td>
<td>$29.35</td>
<td>$352.20</td>
<td>$704.40</td>
<td>$1,056.60</td>
<td>$1,408.80</td>
<td>$1,761.00</td>
</tr>
<tr>
<td>85 - 89</td>
<td>$9.51</td>
<td>$47.56</td>
<td>$570.66</td>
<td>$1,141.32</td>
<td>$1,711.98</td>
<td>$2,282.64</td>
<td>$2,853.30</td>
</tr>
<tr>
<td>≥ 90</td>
<td>$15.41</td>
<td>$77.04</td>
<td>$924.42</td>
<td>$1,848.84</td>
<td>$2,773.26</td>
<td>$3,697.68</td>
<td>$4,622.10</td>
</tr>
</tbody>
</table>

- Free will preparation service is available for retirees who apply and are approved for $10,000 or more in coverage.
ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

<table>
<thead>
<tr>
<th>Name of Group Customer/Employer</th>
<th>Group Customer #</th>
<th>Report #</th>
<th>Sub Code</th>
<th>Branch</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Louisville - Retiree</td>
<td>149183</td>
<td>149483</td>
<td>0003</td>
<td>0001</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Hire (MM/DD/YYYY)</th>
<th>Coverage Effective Date (MM/DD/YYYY)</th>
</tr>
</thead>
</table>

YOUR ENROLMENT INFORMATION (To be Completed by the Retiree)

<table>
<thead>
<tr>
<th>Name (First, Middle, Last)</th>
<th>Social Security #</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-</td>
<td>Male</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street, City, State, Zip Code)</th>
<th>Date of Birth (MM/DD/YYYY)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone #</th>
<th>Email Address</th>
<th>New Enrollment</th>
<th>Change in Enrollment</th>
</tr>
</thead>
</table>

- New Enrollment
- Change in Enrollment

If due to a Qualifying Event, enter event date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

- If you are enrolling during the initial enrollment period, you must complete a Statement of Health form if you are enrolling for more than $10,000 of Supplemental/Optional Life Insurance.

Term Life Insurance

- Basic Life
- Supplemental/Optional Life

- $5,000
- $10,000
- $15,000
- $20,000
- $25,000

1 Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance.

GEF02-1
ADM

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

GEF09-1
FW

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer:

University of Louisville (Class 2 – Retiree)

Page 1 of 1

EF-ST100M-NW (03/12)
New York: Only applies to Accident and Health Benefits (AD&D/Disability/Dental). Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim or the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years, and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF009-1
FW

**BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE**

If you have previously designated a beneficiary under this Group Customer’s plan, such designation will remain in effect. Any MetLife payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below.

I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death.

I understand I have the right to change this designation at any time.

<table>
<thead>
<tr>
<th>Primary Beneficiary Full Name (Last, First, Middle Initial)</th>
<th>Relationship</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Address (Street, City, State, Zip Code)</th>
<th>Share %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).

TOTAL: 100%

If all of the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

<table>
<thead>
<tr>
<th>Contingent Beneficiary Full Name (Last, First, Middle Initial)</th>
<th>Relationship</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Address (Street, City, State, Zip Code)</th>
<th>Share %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).

TOTAL: 100%

**DECLARATIONS AND SIGNATURE**

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
3. I have read the applicable Fraud Warning(s) provided in this enrollment form.

[Sign Here]

Signature of Retiree: ___________________________  Print Name: ___________________________  Date Signed (MM/DD/YYYY): ___________________________
INSTRUCTIONS

FOR THE STATEMENT OF HEALTH FORM AND THE AUTHORIZATION FORM THAT FOLLOW THIS SECTION

INSTRUCTIONS TO THE RECORDKEEPER (The Recordkeeper may be the Group Customer, a Third Party Administrator or MetLife.)
1. Fill in the Group Customer Information and Insurance Information on the Statement of Health form.
2. Give the forms to the Employee.

INSTRUCTIONS TO THE EMPLOYEE
1. Fill in your name and Social Security Number on the Statement of Health form. The Employee's Name and the Employee's Social Security Number must appear on the form.
2. Give the forms to the Proposed Insured to complete and send to MetLife.

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee, the Employee's Spouse or the Employee's Child.) A separate Statement of Health form must be completed by each Proposed Insured.

Based on the enrollment form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. The Employee should fill in the Employee's name and Social Security Number and give the form to you.
2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. After completion, make a copy of both completed forms for your records and FAX or MAIL the original forms to MetLife.

For questions, call MetLife at 1-800-838-8420, prompt 1 (Statement of Health Unit) or email us at eoi@metlife.com.

Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information required may be a physical examination, paramedical exam, or an Attending Physician's Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your Statement of Health form may be performed by our affiliate, MetLife Global Operations Support Centre Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company's obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

<table>
<thead>
<tr>
<th>Name of Group Customer/Employer/Association</th>
<th>Group Customer #</th>
<th>Reporting Location #</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Louisville</td>
<td>149183</td>
<td>149183</td>
</tr>
</tbody>
</table>

Street Address: 1980 Arthur Street, Suite 100
City: Louisville
State: KY
Zip Code: 40208

INSURANCE INFORMATION (To be Completed by the Recordkeeper)

Term Life Insurance
- [ ] Basic Life: Indicate amount subject to medical underwriting $_____
- [ ] Supplemental/Optional Life: Indicate amount subject to medical underwriting $_____

Employee Information (To be Completed by the Employee)

<table>
<thead>
<tr>
<th>Name of Employee (First, Middle, Last)</th>
<th>Social Security # of Employee</th>
</tr>
</thead>
</table>

Your Information (To be Completed by the Proposed Insured)

<table>
<thead>
<tr>
<th>Name (First, Middle, Last)</th>
<th>Relationship to Employee</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sell</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street Address
City
State
Zip Code

Date of Birth (MM/DD/YYYY)
Daytime Phone #
Home Phone #
Email Address

*For Washington State residents, Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

GEF09-1
HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, “you” and “your” refers to the person for whom insurance is being requested.

Your name ___________ Employee’s Social Security/identification # ____________________________

1. Your height ___ feet ___ inches Your weight ___ pounds

2. Are you now on a diet prescribed by a physician or other health care provider? If “yes” indicate type ________________________________

3. Are you now pregnant? If “yes,” what is your due date (month/day/year)? ________________________________

4. Are you now, or have you in the past 5 years, used tobacco in any form?

5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?

6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug?

7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?

8. Are you now receiving or applying for any disability benefits, including workers’ compensation?

9. Have you been Hospitalized as defined below (not including well-baby delivery) in the past 90 days?

   Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.

10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?

11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

   a. cardiac or cardiovascular disorder?
   b. stroke or circulatory disorder?
   c. high blood pressure?
   d. cancer; Hodgkin’s disease, lymphoma or tumor? Indicate type ________________________________
   e. anemia, leukemia or other blood disorder? Indicate type ________________________________
   f. diabetes? Your age at diagnosis? _____ □ Check if insulin treated
   g. asthma, COPD, emphysema or other lung disease? Indicate type ________________________________
   h. ulcers, stomach, hepatitis or other liver disorder? Indicate type ________________________________
   i. colitis, Crohn’s, diverticulitis or other intestinal disorder? Indicate type ________________________________
   j. memory loss?
   k. epilepsy, paralysis, sciatica, dizziness or other neurological disorder?
   l. Epilepsy, chronic fatigue syndrome or fibromyalgia?
   m. multiple sclerosis, ALS or muscular dystrophy?
   n. lupus, scleroderma, auto immune disease or connective tissue disorder?
   o. arthritis? □ osteoarthritis □ rheumatoid □ other type
   p. back, neck, knee, spinal, joint or other musculoskeletal disorder?
   q. carpal tunnel syndrome?
   r. kidney, urinary tract or prostate disorder? Indicate type ________________________________
   s. thyroid or other gland disorder? Indicate type ________________________________
   t. mental, anxiety, depression, attempted suicide or nervous disorder?
   u. sleep apnea

For “yes” answers, please provide full details on the next page in Section 2, then complete Section 3. If all questions are answered “no,” you may proceed directly to Section 3 on the next page.
SECTION 2 – Please provide full details below for each “Yes” answer to the preceding questions 1-11. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MTF may contact you for additional or missing information.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Condition/Diagnosis</th>
<th>Medication Prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Diagnosis (Month/Year)</th>
<th>Date of Last Treatment (Month/Year)</th>
<th>Type of Treatment</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Treating Health Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Physician’s Name:</td>
</tr>
<tr>
<td>Date of last visit:</td>
</tr>
<tr>
<td>Reason for visit:</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Street</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
</tr>
<tr>
<td>Telephone ( )</td>
</tr>
</tbody>
</table>

<table>
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<tbody>
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<td></td>
<td>Yes</td>
</tr>
</tbody>
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<tr>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
</tr>
<tr>
<td>Telephone ( )</td>
</tr>
</tbody>
</table>

SECTION 3

1. Personal Physician’s Name: ___________________________ Telephone: ( )
   Address (Street, City, State, Zip Code): ___________________________
   Date of last visit (MM/DD/YYYY): ___________________________ Reason for visit: ___________________________

2. Are you currently taking any other prescribed medications?  □ Yes  □ No
   Medication: ___________________________ Condition/Diagnosis: ___________________________
   Prescribing Physician’s Name: ___________________________ Telephone: ( )
FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)] Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.

Signature of Proposed Insured: ____________________________  Print Name: ____________________________  Date Signed: (MM/DD/YYYY)

If a child proposed for insurance is age 18 or over, the child must sign this Statement of Health. If the child is under age 18, a Personal Representative for the child must sign, and indicate the legal relationship between the Personal Representative and the proposed insured. A Personal Representative for the child is a person who has the right to control the child’s health care, usually a parent, legal guardian, or a person appointed by a court.

Signature of Personal Representative: ____________________________  Print Name: ____________________________  Date Signed: (MM/DD/YYYY)

Relationship of Personal Representative: ____________________________
Continuation of Benefits for Retirees

Employee ID: _________________
D-O-B: _________________  Employment Date: _________________
Last Day Worked: _________________  Retirement Age: _________________

NAME: ___________________________________  SSN#: ______-______-______
ADDRESS: _______________________________________________________

City  State  Zip Code  Phone#

I wish to continue the following group insurance through the University’s plan for
which I am eligible and understand that I will be billed directly by the University’s
direct billing company for elected coverage(s).

**Payment must be made within 30 days for coverage to continue.

PLEASE CHECK COVERAGES YOU WISH TO CONTINUE:

Health Insurance Plan (up to age 65)

Health Insurance Plan (Single, Couple, Empl + Child(ren), Family)

Dental (Single, Couple, Empl + Child(ren), Family)

Vision (Single, Couple)

AARP (Billed Directly from AARP) (Single, Couple)

Life Insurance ($5,000, $10,000, $15,000, $20,000, $25,000)

Spouse’s Name: ___________________________________________________
D-O-B: ______-______-______  SSN#: ______-______-______

SIGNATURE: ___________________________________________________  DATE: ________

I DO NOT WISH TO PARTICIPATE IN ANY GROUP __HEALTH__DENTAL__VISION OR__LIFE
INSURANCE PLANS THROUGH THE UNIVERSITY FOR WHICH I AM ELIGIBLE.

SIGNATURE: ___________________________________________  DATE: __________
Retirement Account Information

You can contact our retirement vendors directly for current account balances or with questions about your account. You may also access your retirement accounts on-line.

Fidelity:
1.800.343.0860
www.fidelity.com/atwork

TIAA-CREF
1.800.842.2776
www.tiaa-cref.org

You may schedule an appointment to meet with an individual retirement counselor on campus by calling your retirement vendor at:

Fidelity 1.800.642.7131 or by visiting www.fidelity.com/atwork/reservations

TIAA-CREF 1.800.732.8353
Retiree Cardinal Card
Retirees are eligible for a retiree cardinal card. To receive one, please stop by the Campus Card Office and exchange your current employee identification card for a new retiree Cardinal Card.

With the retiree Cardinal Card, you will have access to Intramural facilities, may check out books at the university library, use it as a US Ban ATM card, and can deposit money on the car for your use in the university vending devices such as soda and snack machines, copier, and so forth.

Additionally, you may your card to make purchases at the book store and on most on-campus food service locations. You may also need proof of affiliation with UofL to take advantage of employee discounts and to ride the TARC.

For more information about the Retiree Cardinal Card, please contact the Campus Card Office at 502.852.7520. The Campus Card Office is located in Houchens Building on Belknap Campus, Lower Level, Room 08K.

Please visit our U of L Discounts Page to find out discounts which are available to you as a retiree: http://louisville.edu/hr/gptw/discounts/

Retiree Email
For details about UofL’s email policy for retirees please visit http://louisville.edu/email/retirees/.

Want to keep receiving UofL Today?
To keep receiving UofL Today after your retirement, subscribe to the ULT RETIREES listserv. Click the following link to go to the online subscription page. Enter your name and email address, then scroll to the bottom and click Join ULT RETIREES. You will receive a notice in your email inbox asking you to click a link to confirm your subscription. Be sure to take this action to continue receiving UofL Today.
The university recognizes that problems of a personal nature can have an adverse effect on an individual's job performance. The university Employee Assistance Program (EAP) provides confidential assistance to faculty, staff, and their dependents through the Human Development Company. The Human Development Company can provide assistance on a broad range of human problems such as emotional/behavioral, family and marital, alcohol and/or drug, financial, legal, and other personal problems. The university pays the cost of the EAP service.

The Human Development Company also offers a variety of resources at its website. Visit [www.humandev.com](http://www.humandev.com) click on the Work/Life button bar, select "New Members Register Here", type University of Louisville in the company name box, and chose an ID and password. Once you do this you will have access to a variety of useful information in the following areas:

- **HEALTH** - Over 2,000 articles, Hundreds of videos, and dozens of health assessments and tools
- **LEGAL** - Over 1,000 articles, and a searchable database of over 400,000 attorneys
- **FINANCIAL** - 140 calculators, 95 common federal tax forms, thousands of state-specific tax forms and over 1000 articles
- **TRAINING** - 45 interactive tools and videos and over 100 articles
- **BALANCED LIFE** - 100 interactive tools and videos and over 100 articles
- **MENTAL HEALTH** - Hundreds of articles, over 50 videos, quizzes and 6 mental health assessments

If you have difficulty accessing the Human Development Company website or need to contact HDC to schedule a confidential appointment, the following is HDC's contact information:

Louisville call - 589-HELP (4357)
Long Distance - 1-800-877-8332
Call 24 hours a day, 7 days a week.
To: U of L Retirees

From: The University of Louisville Association of Retired Personnel
       Bill Forman, President and
       Bev Daly, Chair of Membership & Communication

RE: ULARP Membership

We, as board members of ULARP, take this opportunity to welcome you to the association. Your membership is our gift to you for the remainder of this calendar year. We hope you will accept it and we look forward to you becoming an active member. After your complimentary membership expires in December of this year, dues are $10 annually. Lifetime memberships for $100 are also available.

The mission of the University of Louisville Association of Retired Personnel (ULARP) is “to serve U of L retirees by informing, advocating, and connecting; to enrich their quality of life and to benefit the University.” It is a great way for retired faculty and staff to stay connected with the University, share social and educational programs, and stay involved with friends and colleagues while developing new interests.

ULARP is dedicated to serving as your voice about issues and benefits affecting the retiree population. We are constantly developing innovative ways to keep our membership abreast of those activities that impact our lives. We work with the administration of the University to make sure that the needs of our retiree population are not forgotten; for example, board members serve on important University committees such as the Human Resources Advisory Committee. Our quarterly newsletter outlines all ULARP activities and provides news of general interest about UofL and the greater community. The directory, published every other year, will help you keep in touch with new and old friends. The ULARP website at http://louisville.edu/retired offers current information about retiree benefits and all of our fun-filled and informative activities.

Congratulations on your retirement and welcome to what we hope will be a very long and healthy phase of your life, filled with new and exciting adventures.