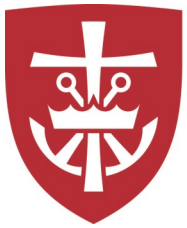

KING'S COLLEGE

TRANSFORMATION. COMMUNITY. *HOLY CROSS.*

Employee Benefits Open Enrollment

July 1, 2015

Creative Benefits, Inc.

strategies to insure your success

Introducing the

Employee Service Representative *Team*

Benefits can be confusing. Insurance companies are hard to reach.

We understand. Trust the ESR team at Creative Benefits, Inc. to help. The team members' combined benefits experience of over 35 years will guide you through the confusion.

Your ESR will assist you with…

- questions or concerns about your benefits;
- a claim that was denied by your insurance;
- a doctor bill for which you are not responsible;
- ordering a new ID card;
- enrolling in benefits for the first time or making changes;
- finding providers that are in your network.

Your ESR Team

Charmaine Harrison-Tummings

ESR Team Leader

Marie D'Antonio

Katelyn Martin

Christa Wisneski

Arielle Kovalich

Marlene Loose

Please help us to help you…

When initially contacting us be prepared to provide your name, subscriber name and company, subscriber social security number or ID, and date of birth.

Hours of Operation

7:30 a.m. to 6 p.m.

Phone

844-231-8414

Email

ESR@creativebenefitsinc.com

2015 OPEN ENROLLMENT - Overview

It is the goal of King's College to offer a strong benefits program while striving to maintain an equitable cost versus benefits balance. Our commitment to a well-rounded benefits program goes beyond medical and prescription benefits to include dental and vision coverage as well as life insurance and long term disability.

As a Full-Time eligible employee, the following benefits are available to you and outlined on the following pages

How to Enroll

Please Note: You must take action in order to secure coverage with all benefit lines on/and after July 1, 2015. You are required to enter the Benefit Enrollment Portal in WebAdvisor to re-elect your benefit options or to make any modifications to your current benefit elections, i.e. **add/ remove a dependent, change plan options or enroll for the first time.**

Once you have made your benefit elections, they will remain in effect until the next Open Enrollment unless you experience a "change in status" e.g. marriage, divorce, birth, adoption, or a child reaching the plan age limit (26).

You have 30 days from the date of a qualifying change in status to notify HR department if you wish to change your benefits. If you do not make the notification within that timeframe, your changes will not be effective until the next Open Enrollment period.

MEDICAL BENEFITS - Blue Cross of NEPA

To locate a participating doctor or facility, visit **www.bcnepa.com** and select "Find a Physician/ Facility" under the Member's website. Next, select the following network: **BlueCare Custom PPO** (for local 13 counties) or **BlueCare PPO Network** (for PA providers outside the 13 counties).

For customer service call: **1-888-338-2211.**

For mental health and substance abuse treatment please contact: **1-800-577-3742.**

	VALUE PLAN CUSTOM PPO - $300 DED	CORE PLAN PPO - $500 DED	PREMIER PLAN PPO - $150 DED
IN NETWORK COVERAGE			
Primary Doctor Visit	$25 copay	$15 copay	$15 copay
Specialist Visit	$35 copay	$25 copay	$25 copay
Preventive Tests such as:			
Mammograms, Pap Smears, Dexa Scan, Cholesterol Screening, Diabetic Care, Lipid Panel, Newborn Screenings, Colorectal Cancer Screenings, Well Baby Immunizations	100% (office visits may be subject to applicable copay)	100% (office visits may be subject to applicable copay)	100% (office visits may be subject to applicable copay)
Complex Radiology (i.e. MRI)	$75 copay per test	$75 copay per test	$75 copay per test
Physical, Speech and Occupational Therapy (45 visits/combined)	20% after deductible	20% after deductible	10% after deductible
Chiropractic Care (15 visits)	20% after deductible	20% after deductible	10% after deductible
Mental Health Outpatient	20% after deductible	20% after deductible	10% after deductible
Durable Medical Equipment	20% after deductible	20% after deductible	10% after deductible
Routine Eye Exam	Not Covered	Not Covered	Not Covered
Retail/Urgent Care	$50 copay	$50 copay	$50 copay
Emergency Room (waived if admitted)	$100 copay no deductible	$100 copay no deductible	$100 copay no deductible
DEDUCTIBLE AND RELATED SERVICES			
In-Network Member Responsibility	**$300 Single $600 Family**	**$500 Single $1,000 Family**	**$150 Single $300 Family**
Co-Insurance	20%	20%	10%
Co-Insurance Maximum	$3,000 Single $6,000 Family	$3,000 Single $6,000 Family	$2,000 Single $4,000 Family
Out-of-Pocket Maximum (deductible & copays are included)	$6,600 Single $13,200 Family	$6,600 Single $13,200 Family	$6,600 Single $13,200 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Inpatient Hospital Care	20% after deductible	20% after deductible	10% after deductible
Outpatient Surgery	20% after deductible	20% after deductible	10% after deductible
Lab / Radiology Services	20% after deductible	20% after deductible	10% after deductible
	BLUECARD NETWORK	**OUT-OF-NETWORK**	**OUT-OF-NETWORK**
Deductible	$1,200 Single $2,400 Family	$2,000 Single $4,000 Family	$1,000 Single $2,000 Family
Co-Insurance	40%	30%	30%
Co-Insurance Maximum	$8,000 Single $16,000 Family	$8,000 Single $16,000 Family	$5,000 Single $10,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited

This is a brief summary only; refer to your member handbook for complete details. If any discrepancies exist between the above and the handbook, the handbook will prevail.

BI-WEEKLY MEDICAL BENEFIT PAYROLL DEDUCTIONS

	Value Plan	*Core Plan*	*Premier Plan*
Single Coverage	$23.00	$49.00	$78.00
Employee + Child(ren) Coverage	$48.00	$106.00	$146.00
Employee + Spouse Coverage	$65.00	$121.00	$176.00
Family Coverage	$94.00	$178.00	$251.00

Please be advised that the Waiver Bonus currently available to employees who choose to opt out of the King's College benefits package will be discontinued effective July 1, 2015.

BLUE CROSS NETWORKS - Custom PPO (Value Plan) and PPO (Core and Premier Plans)

BLUE CROSS CUSTOM PPO (VALUE PLAN) NETWORK

⇒ **In-Network:**

13-county FPLIC PPO provider network

The Custom PPO provider network includes:

- All of First Priority Life's (FPLIC) PPO network providers in our 13-county service area, *PLUS*
  - Blue Distinction Centers for Transplants, *PLUS*
  - Several hospitals and their participating doctors, located just beyond our 13-county service area:

Pennsylvania	Columbia County	Berwick Hospital Center
		Geisinger-Bloomsburg Hospital
	Lehigh County	Lehigh Valley Hospital, Allentown
		St. Luke's University Hospital, Allentown Campus
	Northampton County	St. Luke's University Hospital, Bethlehem Campus
		St. Luke's University Hospital, Anderson Campus, Easton
		Lehigh Valley Hospital-Muhlenberg, Bethlehem
	Schuylkill County	St. Luke's University Hospital, Miners Campus, Nesquehoning
	Union County	Evangelical Community Hospital, Lewisburg
New York	Orange County	Bon Secours Community Hospital, Port Jervis

This hospital is in-network. Not all doctors affiliated with this hospital are in-network.

⇒ **Out-of-Network:** BlueCard PPO National Network of providers.

Who Should Enroll? Those who live and seek care locally.

BLUE CROSS PPO (CORE AND PREMIER PLANS) NETWORK

⇒ **In-Network:** National BlueCard Network. Access to nationwide physicians and facilities.

⇒ **Out-of-Network:** Non participating Blue Cross providers and facilities

Who Should Enroll? Those that reside outside of the 13-county service area, including out of state residents. Or those that seek medical care and treatments outside of the area.

PRESCRIPTION BENEFITS - EXPRESS SCRIPTS

Your prescription drug coverage corresponds with your selected medical plan and is a formulary-based plan. A formulary plan is a defined list of drugs that are FDA approved and selected by the Pharmacy Benefit Manager (PBM), Express Scripts, and BC NEPA based on efficacy and value. If your medications are on the formulary list, you pay only your generic or brand copay. If you are prescribed drugs not on the formulary, ask your doctor to review your list to see if another drug, such as a generic equivalent or therapeutic alternative, can be used to treat your condition.

You can determine how your medications are covered by reviewing the Formulary List. To view the list, go to www.bcnepa.com, click "Rx Drug Benefits" tab a the top of the page, then click Preferred Drug next to the picture and then select "Multi-Tiered Formulary".

	Value Plan	Core Plan	Premier Plan
Retail Pharmacy (30-day Supply)			
Tier 0 – Select Generics	$0 copay	$0 copay	$0 copay
Tier 1 – Generic Formulary	$10 copay	$10 copay	$10 copay
Tier 2 – Brand Formulary	**$35 copay**	$20 copay	$20 copay
Tier 3 – Non-Formulary Brand	**$55 copay**	$35 copay	$35 copay
Coverage for Specialty Prescriptions on the Value Plan will now be 20% of the prescription cost to a maximum of $150.			
Mail Order Pharmacy (90-day Supply)			
Tier 0 – Select Generics	$0 copay	$0 copay	$0 copay
Tier 1 – Generic Formulary	$20 copay	$20 copay	$20 copay
Tier 2 – Brand Formulary	**$70 copay**	$40 copay	$40 copay
Tier 3 – Non-Formulary Brand	**$165 copay**	$105 copay	$105 copay

****Prior Authorizations & Step Therapy****: Certain medications require prior authorization by your physician or the use of a therapeutic alternative prior to the use of the medication that requires prior authorization. Please refer to the formulary for a listing of these medications or call Express Scripts directly at 1-877-603-8399.

Mail Order : There is a mail order program available for maintenance drugs. Maintenance medications are those prescribed for an extended period of time to treat a chronic condition (e.g. high blood pressure). To participate in this program, you should ask your doctor to write two prescriptions for you-one for a 30 day supply to be filled immediately at the retail pharmacy and one for the 90 day supply (plus any refills) to be filled via the mail order program. Then you should complete the Home Delivery Pharmacy Registration form. To download the form, register for your personal account at www.bcnepa.com. Once the mail order pharmacy receives your form, questionnaire and payment the prescription will be sent out directly to your home. To re-order simply call Express Scripts at 1-877-603-8399.

Health Care Reform: The health care reform law has mandated that in-network generic oral contraceptives will be covered under prescription drug with zero cost-sharing in the retail and mail order setting. In-network oral contraceptive brand and non-formulary brand shall have cost-sharing **unless no generic equivalent exists.**

This is a brief summary only; refer to your member handbook for complete details. If any discrepancies exist between the above and the handbook, the handbook will prevail.

DENTAL BENEFITS - GUARDIAN DENTAL

With Guardian, you have the option to choose in-network DentalGuard Preferred providers or out-of-network providers for your care. ** No ID card is necessary. Prior to your appointment, visit www.glic.com to "Manage Your Account" through the Guardian Anytime System where you can print a temporary ID card, view benefits and claims or print important forms. *For out-of-network services, you will be balance-billed for the difference between Guardian's allowance and the provider's charge (in addition to the coinsurance).*

Benefits may be subject to age or frequency limitations. If the charge for any dental treatment is expected to exceed $300, have your dentist submit a dental treatment plan for review before treatment begins.

Go to www.glic.com to find an in-network dentist; select "Find a Provider," and choose the "Find a Dentist" button to search PPO providers. For Customer Service, please call **800-541-7846.**

	In-Network	Out–of-Network
Benefits Maximum	$1,500 Per Calendar Year Per Person	
Annual Deductible *Waived for Diagnostic and Preventive*	$50 Per Individual Per Plan Year $150 Per Family Per Plan Year	
DIAGNOSTIC AND PREVENTIVE		
Exams	100%	100%
Bitewing X-Rays	100%	100%
Cleanings	100%	100%
Fluoride Treatments	100%	100%
Sealants	100%	100%
BASIC SERVICES (After Deductible)		
Fillings	100%	100%
Periodontics	100%	100%
Endodontic	100%	100%
Oral Surgery	100%	100%
MAJOR SERVICES (After Deductible)		
Crowns/Inlays	60%	60%
Bridges	60%	60%
Dentures	60%	60%
ORTHODONTIA SERVICES		
Orthodontic Benefits – Children Only (Up to age 19)	50%	50%
Orthodontic Maximums	$1,500 Per Lifetime Per Child	

BI-WEEKLY DENTAL BENEFIT PAYROLL DEDUCTIONS

Single Coverage	$9.92
Employee + 1 Coverage	$18.21
Family Coverage	$26.63

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VISION BENEFITS - VISION BENEFITS OF AMERICA

Your vision plan through VBA allows you to see any eyecare provider that's right for you. However, your out-of-pocket costs will be lower if you see a VBA participating doctor.
** No ID card is necessary. Prior to your appointment, visit www.visionbenefits.com and either print your benefit form or find a provider that uses the e-claim system. If you use a doctor that files an e-claim, simply make your appointment and tell the doctor that you are a VBA member and that you would like to use the e-claim system.

If you visit a doctor not in VBA's network, you will need to pay the full fee at the time of the service and then submit an itemized bill to VBA for reimbursement.

To find a VBA doctor, visit www.visionbenefits.com. For Customer Service, call **800-432-4966**.

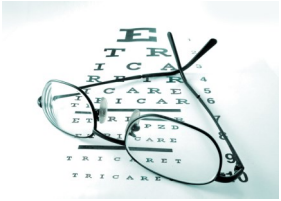
	IN-NETWORK	OUT-OF-NETWORK
EXAMINATIONS (EVERY 12 MONTHS)		
Exams	100%	Up to $40 Reimbursement
Materials	$10 copay	N/A
STANDARD LENSES (Every 12 Months)		
Single Vision	100%	Up to $40 Reimbursement
Bifocal	100%	Up to $50 Reimbursement
Trifocal	100%	Up to $75 Reimbursement
Lenticular	100%	Up to $100 Reimbursement
Progressive	Controlled Cost*	Up to $75 Reimbursement
CONTACT LENSES, EVALUATION & FITTING *(IN LIEU OF GLASSES)* (EVERY 12 MONTHS)		
Elective	Up to $150 allowance	Up to $150 Reimbursement
Medically Necessary	UCR**	Up to $300 Reimbursement
FRAMES (EVERY 12 MONTHS)		
At Provider's Location	$50 wholesale allowance (approximately $125—$150 retail)	Up to $50 Reimbursement

* Progressive lenses typically retail from $150 to $400, depending on lens options. VBA's controlled costs generally range from $45 to $175.

** Usual, Customary and Reasonable as determined by VBA

BI-WEEKLY VISION BENEFIT PAYROLL DEDUCTIONS

Single Coverage	$1.57
Family Coverage	$4.38



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FLEXIBLE SPENDING ACCOUNTS - AmeriFlex

PLAN YEAR: JULY 1, 2015—JUNE 30, 2016

HEALTHCARE SPENDING ACCOUNT

This account will reimburse you with pre-tax dollars for healthcare expenses not reimbursed under your medical plan. In general, expenses incurred to treat a medical condition or to alleviate pain are eligible for reimbursement. ***The annual contribution maximum for the medical spending account is $2,550 per calendar year.*** The amount you elect for the calendar year is deducted on a pre-tax basis for this purpose (deductions are made in equal increments over the course of the year). There is a **$300 minimum** contribution that needs to be made per calendar year.

Some Examples of eligible expenses are:

- Office visit and prescription copays
- Dental expenses, including orthodontia payments (**AmeriFlex will require proof of charges for all dental expenses so please keep your receipts and EOB's).**
- Eye Exams and Materials, Laser Eye Surgery (**AmeriFlex will require proof of charges for all vision expenses so please keep your receipts and EOB's).**
- Certain Over the counter items i.e.: contact lens solutions, band aids

⇒ ***Over-the-counter (OTC) Medications will require a prescription prior to the purchase to be considered an eligible FSA expense.***

DEPENDENT CARE SPENDING ACCOUNT

This account will reimburse you with pre-tax dollars for daycare expenses for your children and other qualifying dependents so that you and your spouse may go to work or school. Up to **$5,000** may be set aside on a pre-tax basis (or **$2,500** if you are married and file separate returns). Eligible Dependents include children under age 13 and children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your federal tax return. **There is a $300 minimum contribution that needs to be made per calendar year.**

Eligible Expenses include:

- Daycare, including nursery school or preschool; Before and after school programs
- Adult daycare
- Summer day camp

DEBIT CARDS

You will receive a debit card that can be used to pay for eligible expenses. However, if a purchase amount does not match a copay amount, you will be asked to substantiate a claim. If you do not respond to the request, your debit card will be deactivated. **You can also submit a paper claim for reimbursement and have the amount deposited into your checking or savings account.**

ROLLOVER PROVISION

King's College has included a rollover provision allowing up to $500 of unused *Medical* FSA funds from 2014/2015 to rollover into their 2015/2016 account with no restriction for accessing those funds in 2015/2016.

***Run Out Claims*:** Employees have 60 days after the end of the plan year to submit for expenses incurred in via a paper claim.

SEE THE DIFFERENCE

	WITH FSA	WITHOUT FSA
Income Before Taxes	$25,000	$25,000
Pre-Tax Expenses (FSA Election)	($1,000)	- $0
Taxable Income	$24,000	$25,000
Taxes (15%)	($3,600)	($3,750)
After Tax Expenses (Medical Expenses)	$0	($1,000)
Take Home Pay	**$20,400**	**$20,250**

TO CHECK YOUR BALANCE:

VISIT

WWW.FLEX125.COM

OR

CALL CUSTOMER SERVICE

888.868.FLEX (3539)

AMERIFLEX®

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Company Name: _____ Location: _____

Employee Name: _____ SSN: _____

Employee Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Plan Year: _____ through _____

Date of Birth: _____ Date of Hire: _____ Effective Date: _____

The Company and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year or during such portion of the year as remains after the date of this agreement . I understand that if I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan and therefore cause me to pay non-reimbursable medical, dependent care, and/or commuter expenses if any with after-tax dollars.

EMPLOYEE'S FLEXIBLE BENEFIT PER PAY DEDUCTION/ALLOCATION

MEDICAL FLEXIBLE SPENDING ACCOUNT

Full Flexible Spending Account	Per pay contribution _____	Date of first payroll _____
_____ Maximum ANNUAL Contribution	Annual contribution _____	Number of remaining pays _____
Limited Purpose Flexible Spending Account	Per pay contribution _____	Date of first payroll _____
_____ Maximum ANNUAL Contribution	Annual contribution _____	Number of remaining pays _____

DEPENDENT CARE SPENDING ACCOUNT

Per pay contribution _____	Date of first payroll _____
_____ Maximum ANNUAL Contribution	Annual contribution _____	Number of remaining pays _____

COMMUTER REIMBURSEMENT ACCOUNT

PARKING	Per pay contribution _____	Date of first payroll _____
_____ Maximum MONTHLY Contribution	Annual contribution _____	Number of remaining pays _____
TRANSIT	Per pay contribution _____	Date of first payroll _____
_____ Maximum MONTHLY Contribution	Annual contribution _____	Number of remaining pays _____

ADOPTION ASSISTANCE

Per pay contribution _____	Date of first payroll _____
_____ Maximum ANNUAL Contribution	Annual contribution _____	Number of remaining pays _____

I UNDERSTAND THAT:

1 My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.

I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election . Note: This does not apply to Commuter Reimbursement Accounts.

The Plan Administrator may reduce, cancel, or otherwise modify this agreement in the event he/she believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

This agreement is sub ect to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan s .

By signing this form I agree to the terms and procedures listed herein.

☐ I was given the opportunity to participate in this Flexible Benefits Plan, and I have decided not to participate at this time.

_____

Employee Signature Date

AMERIFLEX® FSA ENROLLMENT/continued

AF

ADDITIONAL CARDS only applicable if your employer has chosen this option

If you wish to have an AmeriFlex Convenience Card® issued for a spouse or dependent, please be sure your spouse or dependent meets the IRS eligibility guidelines below:

1 For federal tax purposes, a spouse includes all legally married same-sex or opposite-sex spouses, regardless of state residence.
A dependent generally includes any relative of the participant for whom the participant provides over half of their support for the calendar year. A relative includes children, parents, stepchildren, siblings, aunts, uncles, cousins, and in-laws of the participant. Relatives do not need to reside with the participant in order to be dependents, nor do they need to be a certain age or infirmity they need only to be persons for whom the participant has provided over half of their support.

Spouse Name: ______________________________

Address to issue card: ______________________________

Telephone: ______________ Soc. Sec. Number: ______________ Date of Birth: ______________

All dependents must be age 18 or over in order to receive the AmeriFlex Convenience Card®. If you previously added a dependent onto your plan, they will automatically be linked each year. It is your responsibility to add and/or remove dependents as needed. To add additional dependents or to remove dependents, please complete the section below.

Add ☐ | Term ☐
Dependent Name: ______________________________
Address to issue card: ______________________________
If different from participant
Telephone: ______________ Soc. Sec. Number: ______________ Date of Birth: ______________

Add ☐ | Term ☐
Dependent Name: ______________________________
Address to issue card: ______________________________
If different from participant
Telephone: ______________ Soc. Sec. Number: ______________ Date of Birth: ______________

Each AmeriFlex Convenience Card® is issued for a term of three years. Remember that existing cardholders will not receive a new card unless the current card is scheduled to expire . Cards will simply be reloaded for the next plan year with your new election. Upon expiration, AmeriFlex will automatically issue new cards to participants who re-enroll in the new plan year. For new participants, your AmeriFlex Convenience Card® will be sent to your home adress in a plain white envelope.

AUTHORIZATION AGREEMENT FOR ACH DEBITS/CREDITS

I, hereby, authori e AmeriFlex, LLC, hereafter called ADMINISTRATOR, to initiate debits and/or credits to or from my bank account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit and credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge the origination of ACH transactions to or from my account must comply with the provisions of U.S. law.

Depository Name: ______________________ Account Name: ______________________

City: ______________________ State: ______________ Zip: ______________

Routing Number: ______________________ Account Number: ______________________
always nine digits

SELECT ONE: ☐ Checking Account ☐ Savings Account
If you would prefer, please attach a voided check.

CHECK EXAMPLE
⑆123456789 ⑆0000123456 ⑆1234
ROUTING NUMBER ACCOUNT NUMBER CHECK NUMBER

The authori ation is to remain in full force and effect until the ADMINISTRATOR has received written notification from the employee named above of the termination in such time and in such manner as to afford the ADMINISTRATOR and DEPOSITORY a reasonable opportunity to act on it.

Date: ______________ Signature: ______________________________

Upon receipt, the Federal Reserve re uires 1 business days to perform the initial approval of the ACH information. After this time, AmeriFlex will be directly depositing all claim reimbursements into the bank account provided two days after every processing date determined by your employer.

It may take up to business days to have your reimbursements appear in your account, depending upon the automated clearing house utili ed by your bank. e suggest that you contact your bank to confirm when these funds become available in your account. AmeriFlex shall not be responsible for any checks or other debt payments you make whereby you have assumed these funds are available.

LIFE/AD&D INSURANCE / LONG TERM DISABILITY - GUARDIAN

If you have questions about any of the following insurance plans, please contact Luzan Bent at Creative Benefits at **866-306-0200** or lbent@creativebenefitsinc.com.

LIFE/ACCIDENTAL DEATH & DISMEMBERMENT — PAID BY KING'S COLLEGE — GUARDIAN	
Eligible Class	All Eligible employees– Admin & Staff working 35+ hours and Faculty working 15+ hours
Life Benefit	1.5 X Salary to $100,000
Accidental Death & Dismemberment	1.5 X Salary to $100,000
Reduction Schedule	To 67 percent at age 70; to 45 percent at age 75; to 30 percent at age 80
Waiver of Premium	Included
Conversion/ Portability	Included
Accelerated Death Benefit	Included
Benefits Terminate	Upon retirement or termination

IMPUTED INCOME Under Section 79 of the Internal Revenue Code, employer provided group term life coverage will generate additional taxable income to the employee if covered for more than $50,000.

LONG TERM DISABILITY — PAID BY KING'S COLLEGE — GUARDIAN	
Eligible Class	All Eligible Employees- Admin & Staff working 35+ hours and Faculty working 15+ hours
LTD Benefit	60 percent to $4,000 monthly
Benefit Duration	Social Security Normal Retirement Age
Benefits Begin After	180 days
Pre-Existing Condition Limitation	3/12-A pre-existing condition is defined as one where you sought treatment for 3 months prior to being covered.

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VOLUNTARY LIFE INSURANCE - GUARDIAN

If you have questions about any of the following insurance plans, please contact Luzan Bent at Creative Benefits at **866-306-0200** or lbent@creativebenefitsinc.com.

VOLUNTARY LIFE BENEFIT (PAID BY EMPLOYEE) — GUARDIAN	
Life Benefit	**Employee**: $10,000 increments up to $300,000 (Guarantee Issue: $50,000) **Spouse**: $10,000 increments up to $300,000– not to exceed 50% of employee election. (Guarantee Issue: $10,000) **Child (14 days—26 if FT student)**: $10,000 (Guarantee Issue: $10,000)
Reduction Schedule	To 67 percent at age 70; to 45 percent at age 75; to 30 percent at age 80
Portability/ Conversion Option	Termed coverage can be continued on an individual basis should you leave. (Termed rates also age banded)
Accelerated Death Benefit	75% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $300,000.
Waiver of Premium	If it is determined that you are totally disable, your life insurance benefit will continue without payment of premium, subject to certain conditions.

Employees can opt to purchase additional life insurance through payroll deductions. The rates are age-banded, therefore your rates will change only when you move from one age-band to another. Employees and dependents who are currently enrolled and who do not wish to make any changes will continue to be enrolled for the upcoming plan year.

Please note that employees have to elect coverage for themselves in order to eligible to elect dependent coverage.

Please see the Human Resources Department or go to http://www.kings.edu/hr/benefits to obtain the necessary forms for enrollment in this voluntary benefit.

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