Guidelines/Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan’s Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members’ medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan’s network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan’s Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.
Discover Your Benefits

Let’s explore your benefit plan options, programs and resources.

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<tr>
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<th>Page #</th>
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</tbody>
</table>
Eligibility & Enrollment
Time to answer some questions...

Who can enroll?
If you are a regular full time employee that is regularly working a minimum of 20 hours per week for the University, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) (hereinafter referred to as “registered domestic partner”) and/or eligible children.

An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee’s state registered domestic partner that does not meet the definition of the employee’s tax dependent under IRC Section 152.

When does coverage begin?
Regular, full-time employees: You are eligible to enroll on your date of hire, but your coverage begins the first of the month coinciding with or following your date of hire.

Your enrollment choices remain in effect through the end of the benefits plan year, (January 1, 2022 – December 31, 2022). If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status event during the plan year. Please check with your plan administrator and your Section 125 plan document on any applicable status change events that would allow you to make a mid-year election change.

How do I get started with my enrollment?

- Please visit https://www.scu.edu/hr/workdayatscu/ for Workday information (quick reference guides, how to videos and job aids).
- If you have questions when completing your enrollment forms, contact Human Resources.
What if my needs change during the year?

You are permitted to make changes to your benefits after the open enrollment period if you have a change in status event as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the status change event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- You or your spouse’s loss or gain of coverage through our organization or another employer.
- Death of a dependent.
- An employee (1) was expected to average at least 20 hours of service per week, (2) has a change in employment status where he/she will reasonably be expected to average less than 20 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange due to open enrollment or special enrollment period, and coverage is effective no later than the day immediately following the revocation of your employer-sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of status change events, please refer to the “Santa Clara University document that reflects employer’s permitted status change events (e.g. Section 125 document)” contents.

Do I have to enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as from a State or Federal Health Insurance Exchange.

For information regarding Healthcare Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to “waive” coverage if you have access to coverage through another plan. To waive coverage, you must submit a completed Health Insurance Waiver Form with proof of coverage to Human Resources. If you elect to waive your medical coverage, the University will contribute $75 per pay period. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be January 2023, unless a change in status event occurs.
Medical

Which plan type is right for you?

<table>
<thead>
<tr>
<th>HMO</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A Health Maintenance Organization (HMO) Plan</strong> requires you to select a Primary Care Physician (PCP) and your providers must be contracted with the HMO network. Out-of-network coverage is not available except in the case of an emergency.</td>
<td><strong>A High-Deductible Health Plan (HDHP)</strong> combines traditional medical coverage with a Health Savings Account (HSA). As evident by the name, this plan has a higher deductible you must reach before the plan kicks in.</td>
</tr>
</tbody>
</table>

**Advantages**
- Lower out-of-pocket costs.
- Care coordinated by PCP.
- Tax advantages with an HSA.

**Out-of-pocket costs**
Both copays and coinsurance are generally a lower out-of-pocket expense than a PPO plan.

Your out-of-pocket expenses may be mostly upfront, since you’ll need to satisfy your deductible before your plan kicks in.

**Ideal if...**
- ...you prefer a lower payroll deduction and are comfortable with a PCP directing your care.
- ...you don’t usually need much care throughout the year, this plan might be right for you. There is a higher deductible that will need to be satisfied, so please make sure you have funds set aside to pay towards the deductible.

**Note:**
- Out-of-network services without proper PCP referral might not be covered.
- It is beneficial to keep records of your healthcare expenses by retaining your receipts.

Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit [https://scu.edu/hr/staff/benefits/](https://scu.edu/hr/staff/benefits/).

Health Advocate

To support you and your family in navigating the healthcare system and maximizing your benefits, the services offered by Health Advocate can assist with healthcare issues and treatment decisions, and also address time-consuming claims or other concerns.

**Administrative Support**
- Explain coverage and coordinate benefits.
- Research and resolve insurance claims and medical billing issues.
- Identify leading in-network doctors using proprietary MEDIS quality care evaluation approach and make appointments.
- Facilitate any required pre-authorizations for medical services, durable medical equipment and prescription drugs.
- Research ways to reduce prescription drug and other costs.
- Facilitate the transfer of medical records between physicians.

**Clinical Decision Support**
- Answer questions about medical diagnoses and review treatment options.
- Research and identify the latest, most advanced approaches to care.
- Coordinate clinical services related to medical care and identify top experts and Centers of Excellence across the country for initial consults and second opinions.
- Discuss the cost and quality of medical services to help members make informed decisions.
- Help employees prepare for doctor visits, review results and plan future actions.

Contact your personal Health Advocate toll-free at 866.695.8622.

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How do I find a provider?

To find an in-network HMO provider:

**Kaiser HMO**
- Go to [www.kp.org](http://www.kp.org) and select “Doctors & Locations”.
- Search by location, physician name, medical specialty, or advanced search.
- Use the “Health Plan” drop down menu and select plan name.
- Physician profiles and locations available will appear.

**Blue Shield Access+ HMO**
- Go to [www.blueshieldca.com/networkhmo](http://www.blueshieldca.com/networkhmo) and select the type of provider you are looking for.
- Search by location, physician name, medical specialty, or advanced search.
- Physician profiles and locations available will appear.

**Blue Shield Trio HMO**
- Go to [www.blueshieldca.com/networktriohmo](http://www.blueshieldca.com/networktriohmo) and select the type of provider you are looking for.
- Search by location, physician name, medical specialty, or advanced search.
- Physician profiles and locations available will appear.

To find an in-network HDHP provider:

**Blue Shield HDHP**
- Go to [www.blueshieldca.com/networkppo](http://www.blueshieldca.com/networkppo) and select the type of provider you are looking for.
- Search by location, physician name, medical specialty, or advanced search.
- Physician profiles and locations available will appear.
Prescription Drug (Rx) Benefits

Many FDA-approved prescription medications are covered through the benefits program. Tiered prescription drug plans require varying levels of payment depending on the drug’s tier.

$ Generic formulary (Tier 1): Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.

$$ Brand name medications (Tier 2): A brand-name medication can only be produced by one specified manufacturer and is proven to be the most effective in its class.

$$$ Non-formulary prescriptions (Tier 3): Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company’s preferred formulary list. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding the generic option.

$$$$ Specialty prescriptions (Tier 4): Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

Why pay more for prescriptions?

Use Mail Order
Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply from a walk-in pharmacy. Go to www.kp.org or www.blueshieldca.com to sign-up for mail order delivery service.

Shop Around
Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. Call ahead to determine which pharmacy provides the most competitive price.

Over-the-Counter Options
For common ailments, over-the-counter drugs may provide a less expensive alternative that serves the same purpose as prescription medications.
"I need specific medical care! How much does it cost?"

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>Kaiser HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Description</strong></td>
<td>All your healthcare services must be received from Kaiser providers and facilities.</td>
</tr>
<tr>
<td><strong>Annual Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
</tr>
<tr>
<td><strong>Maximum Calendar Year Out-of-pocket</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Professional Services</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP) / Specialist Visit</td>
<td>$20 Copay / $20 Copay</td>
</tr>
<tr>
<td>Routine Physical Exam / Preventive Care</td>
<td>No Copay</td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$15 Copay; Limited to 30 Visits per Calendar Year</td>
</tr>
<tr>
<td>Optical Dispensing</td>
<td>$175 Eyewear Allowance Every 2 Years</td>
</tr>
<tr>
<td>Hearing Aid Benefit</td>
<td>$2,500 allowance per device; 1 device per ear; 2 devices every 3 years</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>Room &amp; Board</td>
<td>$250 Copay per Admission</td>
</tr>
<tr>
<td>Maternity</td>
<td>Same as other Illness</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$20 Copay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$50 Copay</td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$250 per Admission</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$20 Copay per Visit</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Contraceptive Drugs &amp; Devices</td>
<td>No Charge</td>
</tr>
<tr>
<td>Generic / Tier 1 (30-day supply)</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Formulary / Tier 2 (30-day supply)</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Non-Formulary / Tier 3 (30-day supply)</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Mail Order (100-day supply)</td>
<td>2 x copay</td>
</tr>
</tbody>
</table>

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.
"I need specific medical care! How much does it cost?"

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>Blue Shield of CA Trio HMO</th>
<th>Blue Shield of CA Access+ HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Description</td>
<td>You choose a Primary Care Physician to coordinate all of your healthcare. Services obtained from non-authorized providers will not be covered by Blue Shield.</td>
<td>You choose a Primary Care Physician to coordinate all of your healthcare. Services obtained from non-authorized providers will not be covered by Blue Shield.</td>
</tr>
<tr>
<td>Annual Calendar Year Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Maximum Calendar Year Out-of-pocket&lt;sup&gt;[1]&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Professional Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$20 Copay</td>
<td>$20 Copay</td>
</tr>
<tr>
<td>Teladoc Visit</td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td>Specialist Care Office Visit</td>
<td>$20 Copay</td>
<td>$40 copay for Access+ Specialist $20 copay with PCP referral</td>
</tr>
<tr>
<td>Routine Physical Exam / Preventive Care</td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td>Diagnostic X-ray / Lab</td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td>Chiropractic/Acupuncture Services</td>
<td>$15 Copay</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>20 combined visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aid Benefit</td>
<td>20%, $4,000 benefit maximum every 24 months</td>
<td>20%, $4,000 benefit maximum every 24 months</td>
</tr>
<tr>
<td>Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room &amp; Board</td>
<td>$250 Copay per Admission</td>
<td>$250 Copay per Admission</td>
</tr>
<tr>
<td>Maternity (delivery)</td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td>Urgent Care Center Visit</td>
<td>$20 Copay</td>
<td>$20 Copay</td>
</tr>
<tr>
<td>Emergency Room Visit (waived if admitted)</td>
<td>$100 Copay</td>
<td>$100 Copay</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$250 per Admission</td>
<td>$250 per Admission</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$125 per Surgery</td>
<td>$125 per Surgery</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive Drugs</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Tier 1 (30-day supply)</td>
<td>$10 Copay</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>Tier 2 (30-day supply)</td>
<td>$25 Copay</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Tier 3 (30-day supply)</td>
<td>$50 Copay</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Tier 4 (30-day supply)</td>
<td>20% to $200 Copay</td>
<td>20% to $200 Copay</td>
</tr>
<tr>
<td>Mail Order (90-day supply)</td>
<td>Tiers 1, 2 &amp; 3: 2x Retail Copay Tier 4: 20% up to $400 Copay</td>
<td>Tiers 1, 2 &amp; 3: 2x Retail Copay Tier 4: 20% up to $400 Copay</td>
</tr>
</tbody>
</table>

<sup>[1]</sup> Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.
"I need specific medical care! How much does it cost?"

### Plan Highlights

#### Blue Shield of CA PPO with HSA (HDHP)

<table>
<thead>
<tr>
<th>Annual Calendar Year Deductible</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Individual within Family</td>
<td>$2,800</td>
<td>$5,200</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Maximum Calendar Year Out-of-pocket (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,425</td>
<td>$12,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,850</td>
<td>$24,000</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Professional Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Specialist Care Office Visit</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Teladoc Consultation</td>
<td>Covered at 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician Home Visit</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Routine Physical Exam / Preventive Care</td>
<td>Covered at 100%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Diagnostic X-ray / Lab</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Physical, Occupational, Respiratory and Speech Therapy Services</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Chiropractic Services, up to 30 visits per member per calendar year</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Hearing Aid Benefit</td>
<td>Covered at 80%</td>
<td>Covered at 80%</td>
</tr>
<tr>
<td>Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room &amp; Board</td>
<td>Covered at 90%</td>
<td>Covered at 70%, up to $1,000/day</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>Covered at 90%</td>
<td>Covered at 90%</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Covered at 90%</td>
<td>Covered at 70% up to $1000/day</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 (30-day supply)</td>
<td>$10 Copay</td>
<td>$10 Copay then Covered at 75%</td>
</tr>
<tr>
<td>Tier 2 (30-day supply)</td>
<td>$40 Copay</td>
<td>$40 Copay then Covered at 75%</td>
</tr>
<tr>
<td>Tier 3 (30-day supply)</td>
<td>$60 Copay</td>
<td>$60 Copay then Covered at 75%</td>
</tr>
<tr>
<td>Tier 4 (30-day supply)</td>
<td>30% up to $250 Copay</td>
<td>25% of purchase price + 30% up to $250 Copay</td>
</tr>
<tr>
<td>Mail Order (90-day supply)</td>
<td>Tiers 1, 2 &amp; 3: 2x Retail Copay Tier 4: 30% up to $500 Copay</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

---

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.
Supplemental Health Plans
Supplemental Health Plans  
*Be prepared for the unexpected.*

### Long Term Care (LTC) Coverage

In the event that you, your spouse/registered domestic partner, parents, parents-in-law, grandparents or grandparents-in-law are unable to perform activities of daily living such as bathing or dressing, voluntary LTC could provide assistance.

Administered by Genworth, Long Term Care coverage may help pay for adult daycare, assisted living, nursing home care, services received in your own home, and skilled care, such as physical, occupational, respiratory or speech therapy.

If you do not enroll when you first become eligible, you will be required to complete a health questionnaire. All eligible dependents will be asked to complete the health questionnaire, regardless of when they enroll. Visit [https://scu.edu/hr/staff/benefits/](https://scu.edu/hr/staff/benefits/) or call Genworth at (800) 416-3624 or visit [www.genworth.com/](http://www.genworth.com/) using **Group ID: santaclara** and **Access Code: groupLtc** for additional information.
Employee Wellness

A healthier you starts here – mind and body!

Why Wellness?
Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual healthcare costs. We care about your total well-being and encourage all employees to engage in our wellness resources at no-cost.

Wellness Program

Santa Clara University’s Mission to Wellness

The Mission to Wellness Program is designed to enhance the physical and mental well-being of Faculty and Staff at SCU. We provide diverse programs to meet the 8 dimensions of wellness: physical, social, emotional, occupational, financial, environmental, spiritual and intellectual. The benefits gained will promote the creation of a competent, conscientious and compassionate workforce to improve the quality of life for its entire community. SCU offers:

- Personal / Professional Consulting Services
- Health & Wellness Workshops
- Backup Care programs for Children, Adults, and Seniors
- Chair Massages
- Informal Benefits
- Yearly Benefits
- One-on-One Nutrition Counseling
- Financial One-on-One Appointments

For additional information on upcoming events, please visit https://www.scu.edu/hr/staff/wellness/.
Dental Plan

*A smile is the nicest thing you can wear.*

Using the PPO Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you’ll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. To determine whether your dentist is in or out of your insurance network, go to [www.deltadentalins.com](http://www.deltadentalins.com) and search the provider network, or call 800.765-6003.

“I need specific dental care! How much does it cost?”

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>Delta Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$25</td>
</tr>
<tr>
<td>Family</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>$3,500</td>
</tr>
<tr>
<td>Preventive</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Services</td>
<td>100%</td>
</tr>
<tr>
<td>Major Services</td>
<td>60%</td>
</tr>
<tr>
<td>Orthodontia Services</td>
<td></td>
</tr>
<tr>
<td>Adult &amp; Child up to age 26</td>
<td>50%</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.
Vision Plan

Keep a clear focus on your sight.

Vision coverage is offered by Anthem Blue View as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit www.anthem.com/ca.

“I need specific vision care! How much does it cost?”

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam – Every 12 months</td>
<td>$20</td>
<td>$45</td>
</tr>
<tr>
<td>Lenses – Every 12 months</td>
<td>Covered at 100%</td>
<td>$45</td>
</tr>
<tr>
<td>Single</td>
<td>Covered at 100%</td>
<td>$65</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Covered at 100%</td>
<td>$85</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$0 after eyeglass lens copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Progressive</td>
<td>Covered at 100% up to $150</td>
<td>Up to $47</td>
</tr>
<tr>
<td>Frames – Every 24 months</td>
<td>Covered at 100% up to $150</td>
<td>Up to $47</td>
</tr>
<tr>
<td>Additional Pairs of Glasses</td>
<td>Covered at 100% up to $150</td>
<td>Up to $47</td>
</tr>
<tr>
<td>Contacts – Every 12 months, in lieu of lenses &amp; frames</td>
<td>Covered at 100%</td>
<td>Up to $210</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Up to $120</td>
<td>Up to $105</td>
</tr>
<tr>
<td>Cosmetic</td>
<td>Up to $105</td>
<td>Up to $105</td>
</tr>
</tbody>
</table>

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.
Spending Accounts
Make your money work for you.

Health Savings Account (HSA)
By enrolling in the Blue Shield of California High-Deductible Health Plan, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified healthcare expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What to know about your Health Savings Account

- You own your HSA
- Your money rolls over year after year
- You choose how much to contribute
- Paired with a High-Deductible Health Plan
- You receive a tax advantage
What to know about your Health Savings Account

**What are the benefits?**

- HSA funds can grow on a tax-free basis, subject to state law. Please consult your tax advisor for applicable tax laws in your state.
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified healthcare expenses (tax regulations vary by state).
- You may enjoy lower monthly premium payments on your High-Deductible Health Plan (HDHP) as compared to a traditional PPO medical plan.
- **Santa Clara University contributes $50/month to your HSA for employees enrolled in the Blue Shield HDHP.** Employer HSA contributions are contingent upon an employee informing an employer that they have opened an HSA account. Employer HSA contributions are deposited into an employee’s HSA account on a pro-rata basis, contingent upon how many months an employee is HSA eligible and enrolled in Santa Clara University’s HDHP during the year and whether they have a valid account open to receive employer HSA contributions. Employees may forfeit employer contributions if they fail to meet these conditions.

**How do I become eligible to contribute to an HSA?**

- You become eligible to contribute to an HSA if you are covered under a HDHP, you are not enrolled in non-qualified health insurance outside of Santa Clara University’s plan, you are not enrolled in Medicare, you are not claimed as a dependent on someone else’s tax return (excluding a spouse), you have not received any hospital care or medical services from the Veterans Administration, in the last three months (unless these services were related to a service-connected disability) and you are not enrolled in a general Healthcare Flexible Spending Account (Health FSA) or a general Health Reimbursement Arrangement (HRA).

**How do I get started?**

- The most convenient way to pay for qualified expenses is to utilize the debit card. You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account. It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS. If you’re ready to activate your HSA account, you can do so by:
  - Activating your account at [sales.healthequity.com/blueshield](http://sales.healthequity.com/blueshield).
  - Scroll down to find step-by-step video tutorials on various topics.
- Once the HSA account is activated, you can manage and access your account at any time. Consult your tax advisor for taxation information or advice.

**A few rules to keep in mind...**

- **For 2022,** the maximum contribution limit for employee and employer contributions in an employee’s HSA account is $3,650 if you are enrolled in the HSA-PPO for employee-only coverage, and $7,300 for employees with dependent coverage. If you are age 55 or older, you can contribute an additional $1,000 of catch-up contributions.
- It’s important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified healthcare expenses if you are under age 65. For more details about what is considered a qualified healthcare expense, visit [https://www.irs.gov/pub/irs-pdf/p502.pdf](https://www.irs.gov/pub/irs-pdf/p502.pdf).
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon the maximum annual contribution limit for that calendar year, multiplied by the pro-rata portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would be eligible to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first becomes HSA eligible on September 1st of that applicable year. However, under the Full-Contribution Rule, an employee is allowed to contribute the maximum annual contribution amount to his/her/their HSA, regardless of the number of months he/she/they were eligible to contribute to an HSA in that year, if he/she/they are eligible to contribute to an HSA on December 1st of the year and continues to be eligible to contribute to an HSA until December 31st of the following year (i.e., for all subsequent days until December 31st of the following year).

Please consult your tax advisor for applicable tax laws in your state.
# Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible healthcare, dependent care, and transit expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

<table>
<thead>
<tr>
<th>FSA Type</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare FSA</td>
<td>• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance.&lt;br&gt;• For a list of qualified expenses: <a href="https://www.irs.gov/pub/irs-pdf/p502.pdf">www.irs.gov/pub/irs-pdf/p502.pdf</a>&lt;br&gt;• Minimum contribution for 2022 is $300.&lt;br&gt;• Maximum contribution for 2022 is $2,850.</td>
</tr>
<tr>
<td>Limited Purpose FSA</td>
<td>• Employees may want to consider a limited purpose FSA if they are HSA eligible and plan to contribute to an HSA during the plan year.&lt;br&gt;• This FSA may be used to reimburse qualified preventive care, dental, and vision expenses.&lt;br&gt;• For a list of qualified expenses: <a href="https://www.irs.gov/pub/irs-pdf/p502.pdf">www.irs.gov/pub/irs-pdf/p502.pdf</a>&lt;br&gt;• Minimum contribution for 2022 is $300.&lt;br&gt;• Maximum contribution for 2022 is $2,850.</td>
</tr>
<tr>
<td>Dependent Care FSA</td>
<td>• Can be used to pay for a child’s (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves.&lt;br&gt;• For a list of qualified expenses: <a href="https://www.irs.gov/pub/irs-pdf/p503.pdf">www.irs.gov/pub/irs-pdf/p503.pdf</a>&lt;br&gt;• Minimum contribution for 2022 is $600.&lt;br&gt;• Maximum contribution for 2022 is $5,000.</td>
</tr>
<tr>
<td>Commuter Spending Account</td>
<td>• Can be used to cover qualified transit passes, vanpooling, payments for transportation in a commuter highway vehicle, and qualified parking costs.&lt;br&gt;• Transit maximum contribution for 2022 is $280 per month.&lt;br&gt;• Cash reimbursement is not allowed. You must use the FSA Debit card for all parking and transit purchases.</td>
</tr>
</tbody>
</table>

## What are the benefits?
- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

## How do I use it?
You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit [www.discoverybenefits.com](http://www.discoverybenefits.com) to access Discovery Benefits’ online portal.

## A few rules you need to know:
- You may carryover up to $570 from your 2021 health FSA to the 2022 plan year.
- Although the plan year runs from January 2022 through December 2022, the plan allows an annual run-out period through March 31st. 2023 allowing you to seek reimbursement for any expenses incurred during the plan year (from January 1st, 2022 to December 31st, 2022).

For more details about using an FSA, contact Human Resources.

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**How to use your Flexible Spending Account**

- Determine your estimated FSA healthcare expenses for the plan year
- Set up annual (pre-tax) deductions from your paycheck
- Use FSA debit card or submit a claim to your administrator with receipts as proof of your incurred eligible expenses
- The plan allows up to $550 of FSA funds to roll over to the next year
Life & Disability
Protection for your loved ones.

Basic Life and AD&D

In the event of your passing, life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your accidental death & dismemberment (AD&D) coverage may apply.

Paid for in full by Santa Clara University, the benefits outlined below are provided by Sun Life:

- Basic Life Insurance of $70,000.
- AD&D of $70,000.
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

Additional Benefits include access to Assist America:

- **Emergency Travel Assistance**: Provides employees and their families with a variety of services for a medical, dental, or legal emergency when they travel away from home.

- **Identity Theft Protection**: Provides services that protect employees’ personal financial information and help restore it if compromised.
Voluntary Life

If you would like to supplement your employer paid insurance, additional life and AD&D coverage for you and/or your dependents is available on a voluntary basis through payroll deductions from Sun Life.

For employees:

- Increments of $10,000 up to a $500,000 maximum with a guarantee issue benefit of $300,000 if you enroll in the plan within 30 days of your initial eligibility.

For your spouse:

- Increments of $5,000 up to a $100,000 maximum or 50% of the Employee’s Basic and Voluntary Life amount combined, whichever is less. The guarantee issue benefit is $50,000 if you enroll in the plan within 30 days of your initial eligibility.

For your child(ren):

- From birth up to 6 months of age, flat $500; Over 6 months old up to age 26, increments of $2,000 up to a maximum $10,000.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

Voluntary Life insurance rates vary by age and coverage levels. Rates are subject to change when there is a change in coverage or age.

If you do not enroll in the plan within the initial enrollment period or during Open Enrollment, any amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Required! Are your beneficiaries up to date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time.
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.
- To select or change your beneficiary, log in to Workday or contact Human Resources.
Short & Long Term Disability

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans | Coverage Details
--- | ---
Short Term Disability (STD) | • Administered by Matrix, STD coverage provides a benefit equal to 60% of your earnings, up to $1,400 per week for a period up to 52 weeks.
• The plan begins paying these benefits at the time of disability/after you have been absent from work for 7 consecutive days.
• For additional information please visit: [https://scu.edu/hr/quick-links/staff-policy-manual/policy-603—short-term-disability-benefits/](https://scu.edu/hr/quick-links/staff-policy-manual/policy-603—short-term-disability-benefits/)

Long Term Disability Coverage (LTD) | • If your disability extends beyond 360 days, the LTD coverage through Reliance Standard can replace 66 2/3% of your earnings, up to maximum of $10,000 per month.
• Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.
• For additional information please visit: [https://scu.edu/hr/quick-links/staff-policy-manual/policy-604—long-term-disability/](https://scu.edu/hr/quick-links/staff-policy-manual/policy-604—long-term-disability/)

Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.
Retirement

Make retirement a reality, not a wish.

University Retirement Plan: 401(a) Retirement Plan
The Santa Clara University Defined Contribution Plan

- The equivalent of 15% of your base salary from January 1, 2022 – October 15, 2022 is submitted on your behalf to the retirement fund sponsor of your choice each pay period. Then the equivalent of 10% of your base salary beginning October 16 is submitted on your behalf of the retirement fund sponsor of your choice each pay period. This benefit is fully funded by Santa Clara University.

- Choose either Fidelity Investments or TIAA as your fund sponsor for this plan. Fidelity and TIAA Investments has over 50 investment options. Please see fund performance and prospectus of the appropriate plan sponsor for details.

- You are 100% vested once you have worked in a benefits eligible position for a minimum of 1000 hours in each of 2 consecutive calendar years.

Voluntary Retirement Plan: 403(b) Retirement Plan
The Santa Clara University Tax Deferred Annuity Plan

- This benefit is funded by voluntary employee contributions expressed in either a flat amount of a percentage of salary. You can contribute any amount you wish up to the IRS calendar year limits.

- Choose either Fidelity Investments or TIAA as your fund sponsor for this plan. Fidelity and TIAA Investments over 50 investment options. Please see fund performance and prospectus of the appropriate plan sponsor for details.

- You are 100% Vested as of the date of your first contribution.

- 2022 maximum contribution is $20,500. If you are age 50 or over, you can contribute an additional $6,500 of catch-up contributions.

Retirement Plan Portal

The University selected Fidelity, one of our current retirement plan vendors, to manage the SCU on-line retirement plans portal. Whether you have your 401(a) or 403(b) account with Fidelity or TIAA, the Retirement Plan Portal will provide you with the ability to:

- Enroll with either or both investment providers;
- View or change your retirement plan contribution amount or percentage (403b only);
- Change investment providers;
- Sign up for one-on-one consultations with Fidelity (for TIAA call 1-800-732-8353); and
- Access links to specific investment provider account information

Please refer to the Plan Enhancement Guide for information on how to access the portal and create your account. For investment elections and distributions/rollovers, contact your investment provider (TIAA/Fidelity) directly.

Note: Per IRS regulations, IRC 415(c), the combined (employer 401(a) contributions and employee 403(b) contributions) cannot exceed the employee’s annual base earnings.

See Summary Plan Description for Details on both plans: https://scu.edu/hr/staff/benefits/.

Marsh & McLennan Insurance Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.
Employee Assistance Program (EAP)
We can all use an extra helping hand from time to time. Whether you need support with a personal relationship or professional challenge, or you’re seeking guidance on a particular subject, the Employee Assistance Program (EAP) provides the tools you need to thrive. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

### Program Component

<table>
<thead>
<tr>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of sessions</td>
</tr>
<tr>
<td>How to access</td>
</tr>
</tbody>
</table>
| Topics may include | Mental Health Support:  
- Marital, relationship or family problems.  
- Bereavement or grief counseling.  
- Substance abuse and recovery.  
Community Support:  
- Childcare and eldercare.  
- Legal services and Identity theft.  
- Financial support.  
- Educational materials.  |
| Who can utilize | All employees, dependent of employees, and members of your household |

### Get in touch:

- By phone: 800.344.4222
- Online: [www.concern-eap.com](http://www.concern-eap.com)
- Website password: scueap
Perks & More

Let's cover the fun stuff.

To round out your benefits package, we offer these additional perks to support both your personal and professional needs.

Holidays

The following paid holidays will be observed:

- New Year’s Day.
- Martin Luther King Jr. Day.
- President’s Day.
- Good Friday.
- Memorial Day.
- Independence Day.
- Labor Day.
- Thanksgiving Day and the day after.
- Christmas Eve and Day.
- New Year’s Eve.

Paid Time Off (PTO)

Paid family leave (PFL) is administered by Matrix Absence Management. All employees are required to make contributions in an amount equal or less than the contribution rate established by the California Employment Development Department for the California State PFL Plan each year. This plan provides wage replacement to those on an approved leave of absence to care for a seriously ill child, spouse, or registered domestic partner, parent, parent-in-law, grandparent, grandchild and sibling. Benefits are also available to parents who need time to bond with a newborn within the first year of life or a child within the first year following adoption or foster care placement.

The plan pays 60% of your base monthly earnings to a maximum weekly benefit of $1,400 and a minimum of $50 for up to 6 weeks.

For additional information please visit: https://scu.edu/hr/maintain-benefits-info/leaves-and-holidays/ or call Matrix Absence Management at (877) 202-0055 or visit https://www.matrixabsence.com/.

This Section of Benefits Applies to Staff Only

Sick time program provides salary continuation for eligible employees during periods of illness, injury, or medical disability such as maternity or periods of post-surgical recuperation. In the event employees are medically disabled for extended periods of time and a medical leave of absence is required, available sick leave will be coordinated as applicable with Short-Term Disability Insurance, Workers’ Compensation, Santa Clara University’s Long-Term Disability plan, and/or Social Security. Please see https://scu.edu/hr/quick-links/staff-policy-manual/policy-613—sick-leave/ for details.

Vacation time is granted to eligible employees for the purpose of rest and relaxation. Vacation leave accrues from the first of the month following the date of hire as a regular or academic staff member and continues during periods of work, sick leave, vacation and other periods of paid leave. Vacation does not accrue for hours worked on an overtime basis. Please see https://scu.edu/hr/quick-links/staff-policy-manual/policy-612—vacation-pay/ for details.
Education Benefits

The University grants education benefits to provide opportunities for personal and educational development for all benefit eligible employees taking Santa Clara University courses for credit. It also has several education benefit programs for spouses, registered domestic partners, and dependent children (as defined by the IRS) of eligible employees. Below is a quick summary of the Education Benefits available eligible SCU employees and their dependents.

For complete detailed information regarding SCU’s education benefits, including eligibility and application processes, please visit: https://www.scu.edu/hr/quick-links/staff-policy-manual/policy-609---education-benefits/

Tuition Remission

Tuition Remission is available for all undergraduate and graduate courses offered in any term at the University, excluding ancillary or continuing education courses, and the executive MBA program. Eligible employees will be granted Tuition Remission for up to a maximum of two undergraduate courses per academic year quarter, or eight units for graduate courses per academic year quarter or semester, and one undergraduate course or four units for graduate courses per summer. All normal course prerequisites must be met. Dependent children attending the Young Scholars' program are also eligible for Tuition Remission.

Tuition Remission does not include other costs such as books, laboratory, application, service, and other fees. All charges other than tuition must be paid to the University in the same manner as required of other students.

Tuition Reimbursement

The Tuition Reimbursement program provides eligible employees with Tuition Reimbursement for themselves or their dependents of up to $2,000.00 per year, with a lifetime benefit limit of $8,000.00 per employee, for tuition and educational fees.

Employees may use Tuition Reimbursement for accredited college courses or vocational certificate programs, provided the courses or programs are job related. Any college, university or vocational program listed by the U.S. Department of Education as accredited post-secondary institutions would qualify. The Tuition Reimbursement program does not provide any time-off from work for employees.

Dependents must be a matriculating student pursuing an Associate or Bachelor's degree or a vocational certificate program. Any vocational program listed by the U.S.

FACHEX

The Faculty-Administrator's children exchange program (FACHEX) is a program in which children of eligible employees of participating Jesuit colleges and universities may apply for undergraduate admission to one of the institutions and, if accepted, are eligible for tuition remission subject to the terms and conditions set by the accepting institution.

Tuition Exchange

The Tuition Exchange program is a national scholarship exchange program for institutions of higher education. Children of eligible employees may apply for undergraduate admission to one of the participating institutions and, if accepted, are eligible for tuition remission subject to the terms and conditions set by the accepting institution. Additional information and a list of participating institutions can be found on the Tuition Exchange website at: www.tuitionexchange.org.
**Kids on Campus**

**About KOC**

Kids on Campus is a non-profit child development center at Santa Clara University that has been in operation since 1969. We are a small community of about fifty families. The infant-toddler program serves children between the ages of 6 weeks and 30 months. Our preschool program is for children from 2.5 through 6 years of age. The facility includes five classrooms and two playgrounds that are designed to meet the needs of our students while providing a safe and provoking environment. Kids on Campus admits students whose families are affiliated through Santa Clara University as faculty or staff. We are a California state licensed childcare center in compliance with fire, health, and licensing standards required by the California State Department of Social Services.

**General Enrollment Information**

Admission to Kids on Campus is handled through a wait list on which all applicants must be registered. If you decline an offered spot, you must resubmit an application. In order for unborn infants to be placed on the wait list, families must have a due date. It is often impossible to predict when and how quickly openings will be available at KOC. We strive to maintain age and gender balance in classrooms. Enrollment is offered in the following order of priority and is only available to children of benefits-eligible faculty and staff:

1. Current families who are part of the KOC community.
2. Children of continuing faculty and staff (tenure track faculty, senior lecturers, full time regular staff).
3. Children of renewable term faculty (academic year adjunct faculty, renewable term lecturers).
4. Children of regular part-time staff.

For more details about KOC, please visit the website at: [https://www.scu.edu/kids-on-campus/](https://www.scu.edu/kids-on-campus/) or contact KOC directly at (408) 554-4771.

**Even More Coverage Options**

**EE Paid Pre-Tax Cancer Protection Plan**

Santa Clara University provides a group voluntary Cancer Protection Plan through American Fidelity. This plan is a “money plan” that pays a predetermined dollar amount to the subscriber following screening, services and treatment associated with cancer. Please see plan materials for details. For additional information please visit: [https://scu.edu/hr/staff/benefits/](https://scu.edu/hr/staff/benefits/) or call American Fidelity at (800) 365-8306 Ext. 310 or visit [http://americanfidelity.com/](http://americanfidelity.com/)

**Golden State Scholarshare Plan (CA 529 Plan)**

This College Savings program allows you to open an account on behalf of a beneficiary that you name. The money you contribute via payroll deduction is invested in special portfolios designed to meet the needs of your designated beneficiaries, and different kinds of investors.

For additional information please visit: [www.scholarshare.com](http://www.scholarshare.com) or call Golden State ScholarShare at (877) 728-4338

**Discounts, Memberships & More**

Santa Clara University offers a variety of other benefits in addition to those listed in this summary. Other benefits include passes to some Athletic events, discounted transit tickets, dining options and performances in the Center for Performing Arts on campus. Human Resources sponsors financial planning and consulting services with Fidelity, TIAA. Human Resources also coordinates quarterly workshops that provide professional development, as well as campus information.

Human Resources also coordinates financial consultations. To schedule an appointment, please contact the HR Service Desk at extension 4392. We encourage you to visit our website at: [https://scu.edu/hr/maintain-benefits-info/additional-benefits/](https://scu.edu/hr/maintain-benefits-info/additional-benefits/) to explore all the benefits of working at Santa Clara University!

**Employee Emergency Loan Program (EELP)**

EELP loans are meant to provide assistance to employees who find themselves facing a financial emergency. The maximum amount of money that can be borrowed is $4,000.00. Repayment is made through semi-monthly payroll deductions authorized by the borrower. There is no interest charged on employee emergency loans. Repayment periods vary from one to three years, depending on the size of the loan.

**Eligibility:** All regular benefits eligible University employees who have successfully completed one year of service and are in good standing (have not been demoted, suspended, or received a written warning or improvement plan from their supervisor in the past three years) are eligible to apply for EELP loans. The EELP program is managed through the Department of Human Resources. To apply for an EELP loan employees must complete an EELP application form and submit it to the Department of Human Resources. The fact that an employee has applied for, been denied, or received an emergency employee loan is kept strictly confidential. Contact the Manager of Benefits for additional information or to apply at 408-554-6900 or [smmata@scu.edu](mailto:smmata@scu.edu).
Costs, Directory, & Required Notices
Cost Breakdown
_All of your rates in one place._

The rates below are effective January 1st, 2022 – December 31st, 2022

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Employee Contribution</th>
<th>SCU Contribution</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Pay Period</td>
<td>Per Pay Period</td>
<td>Per Month</td>
</tr>
<tr>
<td><strong>Blue Shield of California Trio HMO</strong></td>
<td></td>
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<tr>
<td>Employee Only</td>
<td>$8.05</td>
<td>$401.81</td>
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<td>Employee + One Dependent</td>
<td>$85.13</td>
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<tr>
<td>Employee + Two or More Dependents</td>
<td>$160.54</td>
<td>$1,069.03</td>
<td>$2,459.13</td>
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<tr>
<td><strong>Blue Shield of California Access+ HMO</strong></td>
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<tr>
<td>Employee Only</td>
<td>$54.48</td>
<td>$564.91</td>
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<tr>
<td>Employee + One Dependent</td>
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<tr>
<td>Employee + Two or More Dependents</td>
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<td>$1,506.90</td>
<td>$3,716.29</td>
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<td><strong>Blue Shield of California PPO with HSA (HDHP)</strong></td>
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<tr>
<td>Employee Only</td>
<td>$82.39</td>
<td>$693.07</td>
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<td>Employee + One Dependent</td>
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<tr>
<td>Employee + Two or More Dependents</td>
<td>$444.34</td>
<td>$1,882.04</td>
<td>$4,652.75</td>
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<td><strong>Kaiser Permanente HMO</strong></td>
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<tr>
<td>Employee Only</td>
<td>$30.07</td>
<td>$418.46</td>
<td>$897.06</td>
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<tr>
<td>Employee + One Dependent</td>
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<td>Employee + Two or More Dependents</td>
<td>$252.86</td>
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<td><strong>Delta Dental PPO</strong></td>
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<tr>
<td>Employee Only</td>
<td>$0.00</td>
<td>$38.58</td>
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<tr>
<td>Employee + One Dependent</td>
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<tr>
<td>Employee + Two or More Dependents</td>
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<td>$71.42</td>
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<td><strong>Anthem Blue View – Vision Plan</strong></td>
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<tr>
<td>Employee Only</td>
<td>$2.31</td>
<td>$2.52</td>
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<td>Employee + One Dependent</td>
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<td>$3.84</td>
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<td>Employee + Two or More Dependents</td>
<td>$5.39</td>
<td>$7.10</td>
<td>$24.97</td>
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</tbody>
</table>
# Directory & Resources

Below, please find important contact information and resources for Santa Clara University.

<table>
<thead>
<tr>
<th>Information Regarding</th>
<th>Group / Policy #</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue Shield of California</td>
<td></td>
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<tr>
<td>• HMO Trio</td>
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</tr>
<tr>
<td>• HMO Access+</td>
<td>W0067301</td>
<td>800.393.6130 <a href="http://www.blueshieldca.com">www.blueshieldca.com</a></td>
</tr>
<tr>
<td>• PPO with HSA (HDHP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser</td>
<td>979</td>
<td>800.464.4000 <a href="http://www.kp.org">www.kp.org</a></td>
</tr>
<tr>
<td><strong>Dental Coverage</strong></td>
<td></td>
<td></td>
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<tr>
<td>Delta Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PPO</td>
<td>4224</td>
<td>888.335.8227 <a href="http://www.deltadentalca.org">www.deltadentalca.org</a></td>
</tr>
<tr>
<td><strong>Vision Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthem Blue View Vision</td>
<td>175028</td>
<td>866.723.0515 <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
</tr>
<tr>
<td>• PPO</td>
<td></td>
<td></td>
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<tr>
<td><strong>Life, AD&amp;D and Disability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sun Life</td>
<td>942423</td>
<td>800.247.6875 <a href="http://www.sunlife.com/account">www.sunlife.com/account</a></td>
</tr>
<tr>
<td>• Life/AD&amp;D</td>
<td></td>
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<tr>
<td>• Voluntary Life</td>
<td></td>
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</tr>
<tr>
<td>Matrix Absence Management</td>
<td></td>
<td></td>
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<tr>
<td>• STD</td>
<td>877.202.0055</td>
<td><a href="http://www.matrixabsence.com">www.matrixabsence.com</a></td>
</tr>
<tr>
<td>• Paid Family Leave</td>
<td>170701</td>
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<tr>
<td>Reliance Standard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• LTD</td>
<td>170701</td>
<td>800.351.7500 <a href="http://www.reliancestandard.com">www.reliancestandard.com</a></td>
</tr>
<tr>
<td><strong>Flexible Spending Accounts</strong></td>
<td></td>
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<tr>
<td>Discovery Benefits / WEX</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>866.451.3399</td>
<td><a href="http://www.discoverybenefits.com">www.discoverybenefits.com</a></td>
</tr>
<tr>
<td><strong>Health Savings Account</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HealthEquity</td>
<td>877.857.6810</td>
<td><a href="http://www.healthequity.com">www.healthequity.com</a></td>
</tr>
<tr>
<td><strong>401(k) Retirement Plan Adviser</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIAA</td>
<td>800.842.2776</td>
<td><a href="http://www.tiaa.org">www.tiaa.org</a></td>
</tr>
<tr>
<td>Fidelity</td>
<td>800.343.0860</td>
<td><a href="http://www.fidelity.com/atwork">www.fidelity.com/atwork</a></td>
</tr>
<tr>
<td><strong>Employee Assistance Plan</strong></td>
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<tr>
<td>Concern</td>
<td></td>
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<tr>
<td></td>
<td>Access Code: scueap</td>
<td>800.344.4222 <a href="http://www.concern-eap.com">www.concern-eap.com</a></td>
</tr>
<tr>
<td><strong>Voluntary Long Term Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genworth</td>
<td>800.416.3624</td>
<td><a href="http://www.genworth.com">www.genworth.com</a></td>
</tr>
<tr>
<td><strong>Voluntary Cancer Plan</strong></td>
<td></td>
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</tr>
<tr>
<td>American Fidelity</td>
<td>(800) 365-8306 x310</td>
<td><a href="http://americanfidelity.com/">http://americanfidelity.com/</a></td>
</tr>
<tr>
<td><strong>CA 529 Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Golden State ScholarShare</td>
<td>877.728.4338</td>
<td><a href="http://www.scholarshare.com">www.scholarshare.com</a></td>
</tr>
<tr>
<td><strong>Health Advocacy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Advocate</td>
<td>800.695.8622</td>
<td><a href="http://www.healthadvocate.com/members">www.healthadvocate.com/members</a></td>
</tr>
<tr>
<td><strong>Benefits Broker</strong></td>
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<tr>
<td>Marsh &amp; McLennan Insurance Agency LLC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1340 Treat Boulevard, Suite 250</td>
<td></td>
<td>925.482.9300 <a href="http://www.MarshMMA.com">www.MarshMMA.com</a></td>
</tr>
<tr>
<td>Walnut Creek, CA 94597</td>
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<td></td>
</tr>
</tbody>
</table>
Medicare Part D notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDIBLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Credible Coverage. Because your existing coverage is Credible Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer’s group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don’t join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Credible Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
Legal Information Regarding Your Plans

REQUIRED NOTICES

Women’s Health & Cancer Rights Act

The Women’s Health and Cancer Rights Act (WHCPRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer’s plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents’ other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Other midyear election changes may be permitted under your plan (refer to “Change in Status” section). To request special enrollment or obtain more information, contact your Human Resources Representative.

*HIPAA Special Enrollment Opportunities* include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage (1)
- Acquisition of a new spouse or dependent through marriage (1), adoption (1), or birth (1)
- Loss of state Children’s Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) (1)
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing.

However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual’s preexisting condition, regardless of the individual’s age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage becomes available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, if you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

(1) Indicates that this event is also a qualified ‘Change in Status’

(2) Indicates that this event is also a HIPAA Special Enrollment Right

(3) Indicates that this event is also a COBRA Qualifying Event
CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced,
or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
or
- Your spouse’s hours of employment are reduced;
or
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
or
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both);
or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
or
- The parent-employee’s hours of employment are reduced;
or
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
or
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
or
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
- The end of employment or reduction of hours of employment;
or
- The death of the employee; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to anyone covered under the Plan who are spouses, dependent children, or anyone else eligible for COBRA continuation coverage under the plan.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
- Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

How is COBRA continuation coverage provided? (continued)

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children’s Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse’s plan) through which is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after you lose eligibility for coverage under the Plan you have an 8-month special enrollment period (1) to sign up for Medicare Part A or B, beginning on the earlier of:
- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Human Resources
500 El Camino Real
Santa Clara, CA 95053

For More Information
This notice doesn’t fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who can talk to you about the different options, visit www.healthcare.gov.

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement
Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care, or childbirth;
- For care of the employee’s child after birth, or placement for adoption or foster care;
- For care to the employee’s spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

For more information visit https://www.dol.gov/whd/faqfamilymedicalleavewages.pdf.

(1) https://www.healthcare.gov/medicare-and-you
Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a family member who is on covered active duty, or who has been called or ordered to active duty as a result of a serious injury or illness. A covered family member is (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, or is otherwise in outpatient status, or is otherwise on the temporary disability retirement list, for a serious injury or illness (2); a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. (1)

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles. (2)

The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition." (1)

(1) Special rules of the FMLA eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for medical family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA, if they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employer's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement that provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE (866) 487-9243 TTY: (877) 898-5627 www.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do Not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for further details.

Length of Time Coverage Can Be Continued

The period during which you can elect to continue your coverage is equal to the required period of uniformed service, plus an additional 12-month period. The period of uniformed service counts down from the date on which you stop working due to your leave for uniformed services.

Period of Uniformed Service

<table>
<thead>
<tr>
<th>Period of Uniformed Service</th>
<th>Report to Work Requirement</th>
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</thead>
<tbody>
<tr>
<td>Less than 31 days</td>
<td>The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as possible</td>
</tr>
<tr>
<td>31 - 180 days</td>
<td>Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as possible</td>
</tr>
<tr>
<td>181 days or more</td>
<td>Submit an application for reemployment within 90 days after completion of your service</td>
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</tbody>
</table>

Any period if if purposes of an examination for fitness to perform uniformed service

Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as possible

Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service

Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for reemployment is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to “service in the uniformed services.”

- “Uniformed services” means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- “Service in the uniformed services” or “service” means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty training, National Guard duty under federal statute, a period for which a person is absent from employment for examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)
HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE: January 1, 2022

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the “Plan”), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes: when for purposes of marketing and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan Use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Privacy Officer.

You have both the right and choice to tell us to share information with your family, close friends, or others involved in paying for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacists, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to normal term life plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to PHI must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers’ Compensation: We may release health information about you for workers’ compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illnesses.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect or domestic violence; preventing or reducing a serious threat to anyone’s health or safety or for purposes of public health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a “designated record set.” A designated record set includes medical and billing records, enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information; you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- Ask us to limit what we use or share, or disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Follow the duties and privacy practices described in this notice with respect to Information we collect and maintain about you and provide you a copy of the notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose health information that is necessary to carry out the Plan’s functions as a Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by Individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/notlopp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

Santa Clara University
Attention: Human Resources
500 El Camino Real
Santa Clara, CA 95053
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP, and you're eligible for health coverage from your employer, your state may have a premium assistance program to help pay for coverage. If you or your children don't qualify for employer-based coverage, there may be additional programs that can help you pay for insurance.

If you or your children are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP program to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible, contact your State Medicaid or CHIP office to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP program to find out if premium assistance is available.

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.dol.gov/ or call 1-877-KIDS NOW (1-877-543-7669) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program to help pay for coverage. If you or your children don't qualify for employer-based coverage, there may be additional programs that can help you pay for insurance.

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program to help pay for coverage. If you or your children don't qualify for employer-based coverage, there may be additional programs that can help you pay for insurance.

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program to help pay for coverage. If you or your children don't qualify for employer-based coverage, there may be additional programs that can help you pay for insurance.
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<tr>
<th>State</th>
<th>Medicaid and CHIP Website</th>
<th>Medicaid Website</th>
<th>CHIP Website</th>
<th>Phone</th>
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<tbody>
<tr>
<td>SOUTH CAROLINA – Medicaid</td>
<td><a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a></td>
<td></td>
<td><a href="http://healthcare.ri.gov/">http://healthcare.ri.gov/</a></td>
<td>1-888-692-7462</td>
</tr>
<tr>
<td>TEXAS – Medicaid</td>
<td><a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
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<td><a href="http://healthcare.ri.gov/">http://healthcare.ri.gov/</a></td>
<td>1-800-440-0493</td>
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<tr>
<td>VERMONT – Medicaid</td>
<td><a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
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<td><a href="http://healthcare.ri.gov/">http://healthcare.ri.gov/</a></td>
<td>1-800-699-9075</td>
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<tr>
<td>WASHINGTON – Medicaid</td>
<td><a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a></td>
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<td><a href="http://healthcare.ri.gov/">http://healthcare.ri.gov/</a></td>
<td>1-800-699-9075</td>
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<tr>
<td>WEST VIRGINIA – Medicaid</td>
<td><a href="http://www.hca.wa.gov/">http://www.hca.wa.gov/</a></td>
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<td><a href="http://healthcare.ri.gov/">http://healthcare.ri.gov/</a></td>
<td>1-800-699-9075</td>
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<td>SOUTH DAKOTA – Medicaid</td>
<td><a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
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<td><a href="http://www.hca.wa.gov/">http://www.hca.wa.gov/</a></td>
<td>1-888-549-0620</td>
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To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

- U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W., Room N-214B, Washington, DC 20210 or email ebtsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
- U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-214B, Washington, DC 20210 or email ebtsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)
Notes