BENEFITS

INFORMATION GUIDE UNDERSTANDING YOUR OPTIONS

2024

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.

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program 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.

Discover Your Benefits

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

Eligibility & Enrollment

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, 2024 – December 31, 2024. 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?

- Log into Workday and click on your Open Enrollment inbox item. Guides may be found under the Benefits app in Workday.
- If you have questions when completing your enrollment forms, contact Human Resources at scu-benefits@scu.edu

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 Section 125 plan.

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 medical coverage if you have access to coverage through another plan. To waive coverage, you must upload a completed Health Insurance Waiver Form with proof of coverage in Workday. 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 during Open Enrollment for plan year 2025, unless a change in status event occurs.

Medical

Medical

Which plan type is right for you?

HMO	HDHP
A Health Maintenance Organization (HMO) Plan 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.	A High-Deductible Health Plan (HDHP) 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.
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/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.

How do I find a provider?

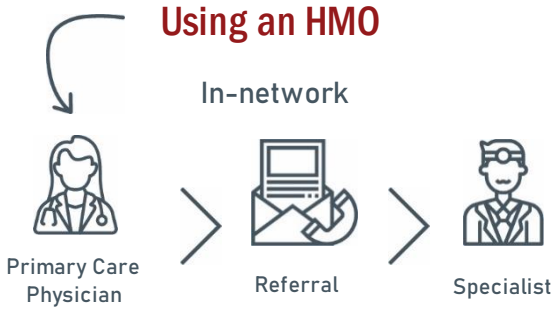
To find an in-network provider:

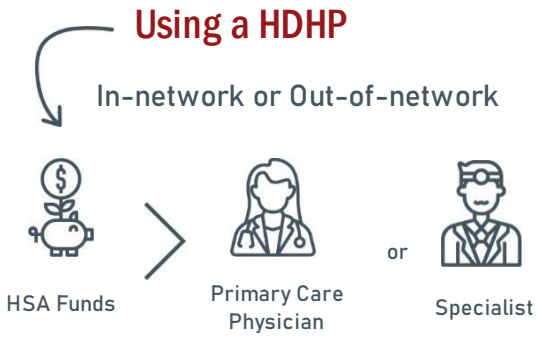
Kaiser

- Go to 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.

Aetna

- Go to www.aetna.com and select “Find a doctor”
- Under Guests, select “Plan from an employer”
- Under Continue as Guest, enter in your zip code and preferred radius and select Search
- From here select the Plan you are interested in reviewing if your provider is within the network, the plans available through SCU include:
    - For the Aetna AWH HMO plan:
        - Under Aetna Whole Health Plans Select the following:
            - (CA) Aetna Whole Health℠ - Northern California HMO (replacement of the Blue Shield Trio HMO)
    - For the Aetna HMO plan:
        - Under Aetna Standard Plans select the following:
            - HMO (replacement of the Blue Shield Access+ HMO)
    - For the Aetna PPO with HSA (HDHP) plan:
        - Under Aetna Open Access Plans select the following:
            - OA Managed Choice POS HDHP (OAMC) (replacement of the Blue Shield PPO Savings)
- Once you have selected the plan above, you will be able to search for providers, urgent care centers, hospitals, mental health providers, etc.





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.aetna.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?"

Plan Highlights	Kaiser HMO
Plan Description	All your healthcare services must be received from Kaiser providers and facilities.
Annual Calendar Year Deductible	
Individual	None
Family	None
Maximum Calendar Year Out-of-pocket [1]	
Individual	$1,500
Family	$3,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP) / Specialist Visit	$20 Copay / $20 Copay
Routine Physical Exam / Preventive Care	No Copay
Diagnostic X-ray and Lab	Covered at 100%
Chiropractic / Acupuncture Services	$15 Copay; Limited to 30 Visits per Calendar Year
Optical Dispensing	$175 Eyewear Allowance Every 2 Years
Hearing Aid Benefit	$2,500 allowance per device; 1 device per ear; 2 devices every 3 years
Hospital Services	
Room & Board	$250 Copay per Admission
Maternity Services	Same as other Illness
Urgent Care	$20 Copay
Emergency Room	$50 Copay
Mental Health & Substance Abuse	
Inpatient	$250 per Admission
Outpatient	$20 Copay per Visit
Prescription Drugs	
Contraceptive Drugs & Devices	No Charge
Generic / Tier 1 (30-day supply)	$10 Copay
Formulary / Tier 2 (30-day supply)	$25 Copay
Non-Formulary / Tier 3 (30-day supply)	$25 Copay
Specialty / Tier 4 (30-day supply)	20% up to $200 Copay
Mail Order (100-day supply)	2 x copay

[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?"

Plan Highlights	Aetna AWH NorCal HMO	Aetna HMO
Plan Description	You choose a Primary Care Physician to coordinate all of your healthcare. Services obtained from non-authorized providers will not be covered by Aetna.	You choose a Primary Care Physician to coordinate all of your healthcare. Services obtained from non-authorized providers will not be covered by Aetna.
Plan Network Detail	(CA) Aetna Whole Health - Northern California HMO	Aetna Standard HMO
Annual Calendar Year Deductible		
Individual/Family	None	None
Maximum Calendar Year Out-of-pocket [1]		
Individual	$2,000	$2,000
Family	$4,000	$4,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Office Visit	$20 Copay	$20 Copay
Specialist Care Office Visit	$20 Copay	$20 Copay
Routine Physical Exam / Preventive Care	No Copay	No Copay
Diagnostic X-ray / Lab	No Copay	No Copay
Chiropractic Services - 20 visits/year	$15 Copay	$15 Copay
Acupuncture Services – 20 visits/year	$20 Copay	$20 Copay
Hearing Aid Benefit	20% copay, $4,000 benefit maximum every 24 months	20% copay, $4,000 benefit maximum every 24 months
Hospital Services		
Room & Board	$250 Copay per Admission	$250 Copay per Admission
Maternity Services	$250 Copay per Admission	$250 Copay per Admission
Urgent Care	$20 Copay	$20 Copay
Emergency Room Visit (waived if admitted)	$100 Copay	$100 Copay
Mental Health & Substance Abuse		
Inpatient	$250 Copay per Admission	$250 Copay per Admission
Outpatient	$20 copay	$20 copay
Prescription Drugs		
Contraceptive Drugs	No Charge	No Charge
Tier 1 (30-day supply)	$10 Copay	$10 Copay
Tier 2 (30-day supply)	$25 Copay	$25 Copay
Tier 3 (30-day supply)	$50 Copay	$50 Copay
Tier 4 (30-day supply)	20% to $200 Copay	20% to $200 Copay
Mail Order (90-day supply)	Tiers 1, 2 & 3: 2x Retail Copay	Tiers 1, 2 & 3: 2x Retail Copay

[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?"

Plan Highlights	Aetna PPO with HSA (HDHP)	
Plan Description	Access to in-network and out-of-network providers. The plan deductible must be met before the coinsurance and copays outlined below will apply. Ability to open a Health Savings Account (HSA) and contribute pre-tax funds to the account.	
Plan Network Detail	OA Managed Choice POS HDHP (OAMC)	
	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual	$2,000	$4,000
Individual within Family	$3,200	$4,000
Family	$4,000	$8,000
Maximum Calendar Year Out-of-pocket (3)		
Individual	$4,000	$8,000
Individual within Family	$4,000	$8,000
Family	$8,000	$16,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Office Visit	Covered at 90%	Covered at 70%
Specialist Care Office Visit	Covered at 90%	Covered at 70%
Physician Home Visit	Covered at 90%	Covered at 70%
Routine Physical Exam / Preventive Care	Covered at 100%	Covered at 70%
Diagnostic X-ray / Lab	Covered at 90%	Covered at 70%
Chiropractic Services - 20 visits/year	Covered at 90%	Covered at 70%
Acupuncture Services - 20 visits/year	Covered at 90%	Covered at 70%
Hearing Aid Benefit Limited to 1 pair of hearing aids every 24 months	Covered at 90%	Covered at 30%
Hospital Services		
Room & Board	Covered at 90%	Covered at 70%
Maternity Services	Covered at 90%	Covered at 70%
Urgent Care	Covered at 90%	Covered at 70%
Emergency Room (waived if admitted)	Covered at 90%	Covered at 90%
Mental Health & Substance Abuse		
Inpatient	Covered at 90%	Covered at 70%
Outpatient	Covered at 90%	Covered at 70%
Prescription Drugs		
Tier 1 (30-day supply)	$10 Copay	N/A
Tier 2 (30-day supply)	$30 Copay	N/A
Tier 3 (30-day supply)	$50 Copay	N/A
Tier 4 (30-day supply)	30% up to $250 Copay	N/A
Mail Order (90-day supply)	Tiers 1, 2 & 3: 2x Retail Copay	Not Covered

(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. Call Genworth at (800) 416-3624 or visit https://scu.myltcguide.com using **Group ID: santaclara** and **Access Code: groupltc** for additional information. If you obtain coverage through Genworth, you will be responsible for making payments to them directly.

Employee Wellness

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:

1. Personal / Professional Consulting Services
2. Health & Wellness Workshops
3. Backup Care programs for Children, Adults, and Seniors
4. Chair Massages
5. Informal Benefits
6. Yearly Benefits
7. One-on-One Nutrition Counseling
8. Financial One-on-One Appointments

For additional information on upcoming events, please visit https://www.scu.edu/hr/benefits/mental-health-and-wellness/


Dental
Plan

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.guardiananytime.com and choose Find a Dentist. The Plan Type is "PPO: Dental Guard Preferred." Alternatively, you may call 800.541.7846.

"I need specific **dental** care! How much does it cost?"

Plan Highlights	Guardian Dental PPO	
	In-network	Out-of-network
Calendar Year Deductible		
Individual	$25	$25
Family	$75	$75
Annual Maximum	$3,500	$3,500
Preventive	100%	100%
Basic Services	100%	80%
Major Services	60%	50%
Orthodontia Services		
Adult	50%	50%
Child up to age 26	50%	50%
Lifetime Maximum	$3,000	$3,000

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

Maximum Rollover

With Maximum Rollover, Guardian will roll over a portion of each member's unused annual maximum into their personal Maximum Rollover Account (MRA). The MRA can be used in future years if a member reaches the plan's annual maximum.

Claims Threshold for MRA eligibility	$1,000
Maximum Rollover Amount	$500
In-Network Bonus Rollover Amount	$750
Maximum MRA Account Limit	$1,500

Vision Plan

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?"

Plan Highlights	Anthem Blue View Vision PPO	
	In-network	Out-of-network
Exam – Every 12 months	$20	$45
Lenses – Every 12 months		
Single	Covered at 100%	$45
Bifocal	Covered at 100%	$65
Trifocal	Covered at 100%	$85
Progressive	$0 after eyeglass lens copay	Not Covered
Frames – Every 24 months	Covered at 100% up to $150	Up to $47
Additional Pairs of Glasses		
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	Covered at 100%	Up to $210
Cosmetic	Up to $120	Up to $105

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

Spending Accounts

Make your money work for you.

Health Savings Account (HSA)

By enrolling in the Aetna 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 Aetna 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 https://www.healthequity.com/.
	  • 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 2024, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $4,150 if you are enrolled in the HSA-PPO for employee-only coverage, and $8,300 for employees with dependent coverage. • 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. • 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 1 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).

(1) 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:

FSA Type	Detail
Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • For a list of qualified expenses: https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/ • Minimum contribution for 2024 is $300. • Maximum contribution for 2024 is currently $3,050.*
Limited Purpose FSA	• 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. • This FSA may be used to reimburse qualified preventive care, dental, and vision expenses. • For a list of qualified expenses: https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/ • Minimum contribution for 2024 is $300. • Maximum contribution for 2024 is currently $3,050.*
Dependent Care FSA	• 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. • For a list of qualified expenses: https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/ • Minimum contribution for 2024 is $600. • Maximum contribution for 2024 is $5,000.*
Commuter Spending Account	• Can be used to cover qualified transit passes, vanpooling, payments for transportation in a commuter highway vehicle, and qualified parking costs. • Transit maximum contribution for 2024 is currently $300 per month.* • Cash reimbursement is not allowed. You must use the FSA Debit card for all parking and transit purchases.

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?

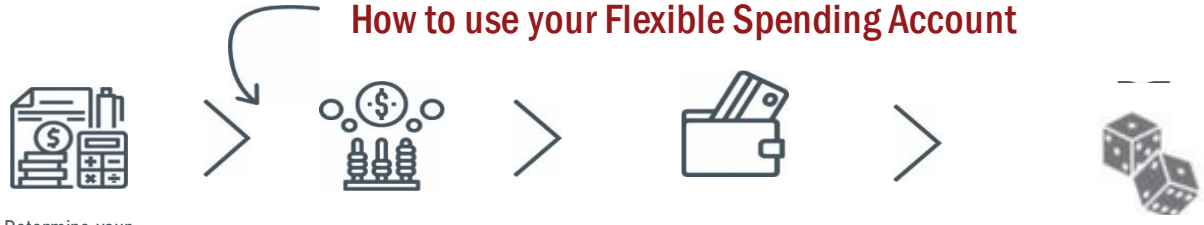
You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit https://benefitslogin.wexhealth.com/ to access Wex Benefits' online portal.

A few rules you need to know:

- You may carryover up to $610 from your 2024 health FSA to the 2025 plan year.*
- Although the plan year runs from January 2024 through December 2024, the plan allows an annual run-out period through March 31st. 2025 allowing you to seek reimbursement for any expenses incurred during the plan year (from January 1st, 2024 to December 31st, 2024.)

* The IRS has not yet announced 2024 maximums and carryover amounts. Human Resources will communicate this information once available. For more details about using an FSA contact Human Resources.

How to use your Flexible Spending Account



Life & Disability

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. Insu rance 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 coverag e or age.

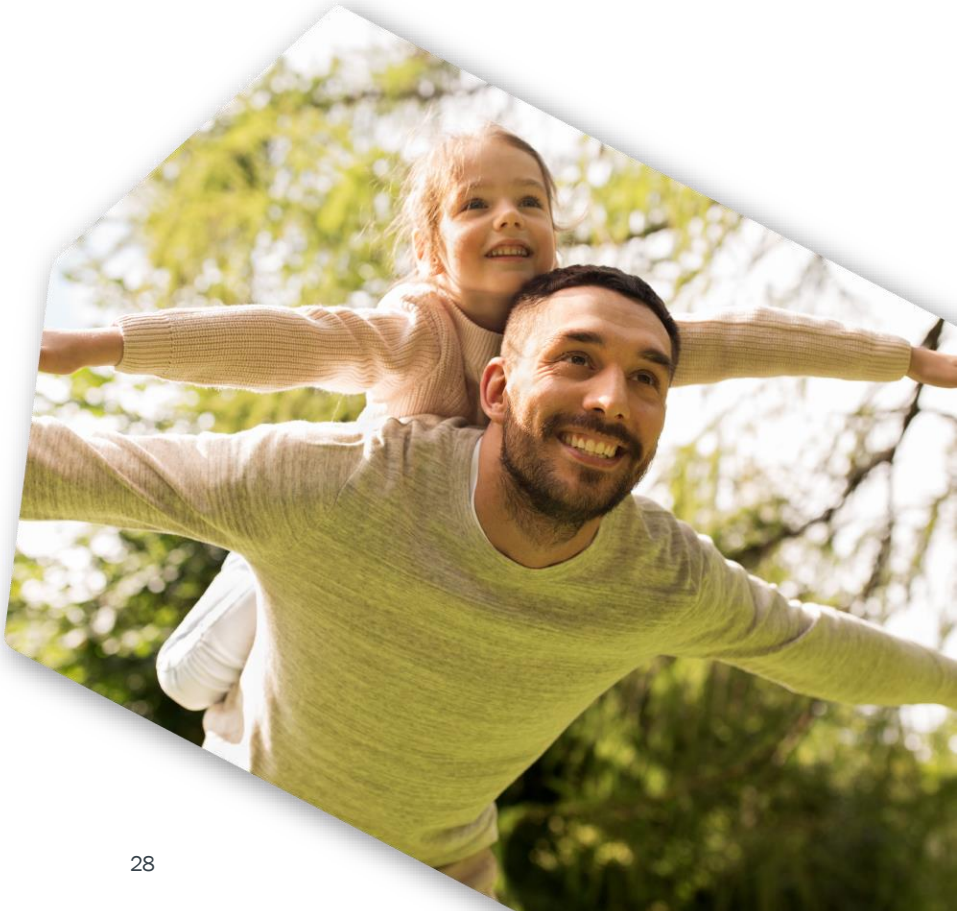
If you do not enroll in the plan within the initial enrollment period or during Open Enrollment, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. During Open Enrollment for 2024 if you are a late entrant, you can enroll up to $10,000 for an employee and $5,000 for spouse without needing to submit proof of good health. 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.



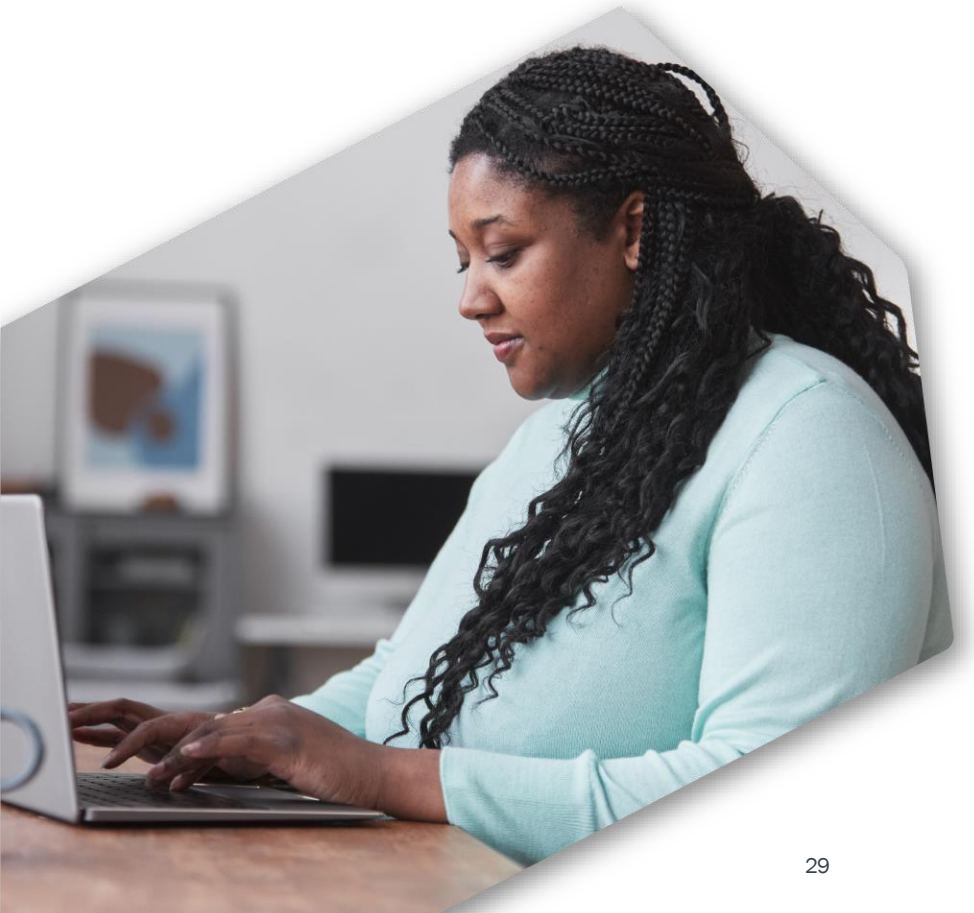
Short & Long Term Disability

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 $1,700* 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/
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/

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

* The University considers the State of California's weekly maximum for State Disability when determining its STD maximum. As of the time this guide was created, the State has not announced the 2024 maximum. If changes are made to the University's maximum, this guide will be updated. The University's maximum will always be the same or more than the State's.



Retirement

Retirement

Make retirement a reality, not a wish.

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

1. The equivalent of 10% of your base salary is submitted on your behalf to the retirement fund sponsor of your choice each pay period. This benefit is fully funded by Santa Clara University.
2. Choose either Fidelity Investments or TIAA as your fund sponsor for this plan. Fidelity and TIAA Investments have over 50 investment options. Please see fund performance and prospectus of the appropriate plan sponsor for details.
3. 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 have 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.
- 2024 maximum contribution is $22,500. 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/.

Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

Your free and confidential go-to resource.

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	Coverage Details
Number of sessions	10 face-to-face sessions per 12 consecutive month period per member per incident
How to access	Phone or face-to-face sessions
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, dependents of employees, and members of your household

Get in touch:

- By phone: 800.344.4222
- Online: https://login.concernhealth.com/enter
- Website password: scueap

Perks & More

Perks & More

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.
- Juneteenth.
- Independence Day.
- Labor Day.
- Indigenous People's Day.
- Thanksgiving Day and the day after.
- Christmas Eve and Day.
- New Year's Eve.

This Section of Benefits Applies to Staff Only

Paid Time Off (PTO)

The **Paid Time Off (PTO)** program allows employees to use a maximum of 24 hours of accrued sick leave during any 12 month period to attend to personal matters. Please see https://www.scu.edu/hr/employee-resources/policies-and-guidelines/staff-policy-manual/policy-617---personal-leave/ for details.

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

Paid Family Leave

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 P FL 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 ad option or foster care placement.

The plan pays 60% of your base monthly earnings to a maximum weekly benefit of $1,700 and a minimum of $50 for up to 8 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/.

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, and online courses. 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 $3,000.00 per year, with a lifetime benefit limit of $12,000.00 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:

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

For more details about KOC, please visit the website at: 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/ or call American Fidelity at (800) 365-8306 Ext. 310 or visit 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 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 through Heffernan. To schedule an appointment, please contact the HR Service Desk at extension 4392. We encourage you to visit our website at: https://www.scu.edu/hr/benefits/perks--rewards/ 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 Director of Employee Development & Wellness for additional information or to apply at 408-544-6990 or smmata@scu.edu .

Costs, Directory, & Required Notices

Cost Breakdown

All of your rates in one place.

The rates below are effective January 1st, 2024 – December 31st, 2024

Coverage Level	Employee Contribution	SCU Contribution	Total Cost
	Per Pay Period	Per Pay Period	Per Month
Aetna AWH NorCal HMO			
Employee Only	$8.50	$439.52	$896.03
Employee + One Dependent	$89.91	$850.92	$1,881.65
Employee + Two or More Dependents	$169.55	$1,174.49	$2,688.08
Aetna HMO			
Employee Only	$57.54	$619.51	$1,354.10
Employee + One Dependent	$244.36	$1,177.44	$2,843.59
Employee + Two or More Dependents	$370.97	$1,660.17	$4,062.28
Aetna PPO with HSA (HDHP)			
Employee Only	$86.82	$759.65	$1,692.93
Employee + One Dependent	$295.45	$1,482.12	$3,555,16
Employee + Two or More Dependents	$468.81	$2,070.59	$5,078.79
Kaiser Permanente HMO			
Employee Only	$36.84	$490.42	$1,054.52
Employee + One Dependent	$205.37	$849.15	$2,109.04
Employee + Two or More Dependents	$309.77	$1,182.38	$2,984.29
Guardian Dental PPO			
Employee Only	$0.00	$41.25	$82.50
Employee + One Dependent	$9.85	$56.60	$132.90
Employee + Two or More Dependents	$22.50	$76.37	$197.74
Anthem Blue View Vision PPO			
Employee Only	$2.31	$2.52	$9.65
Employee + One Dependent	$3.20	$3.84	$14.08
Employee + Two or More Dependents	$5.39	$7.10	$24.97

Directory & Resources

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

Information Regarding	Group / Policy #	Contact Information	
Medical Coverage			
Aetna • AWH HMO • HMO • OAMC POS (HDHP)	237642	877.204.9186	www.aetna.com
Kaiser • HMO	979	800.464.4000	www.kp.org
Dental Coverage			
Guardian • PPO	00056564	800.541.7846	www.guardiananytime.com
Vision Coverage			
Anthem Blue View Vision • PPO	175028	866.723.0515	www.anthem.com/ca
Life, AD&D and Disability			
Sun Life • Life/AD&D • Voluntary Life	942423	800.247.6875	www.sunlife.com/account
Matrix Absence Management • STD • Paid Family Leave	170701	877.202.0055	www.matrixabsence.com
Reliance Standard • LTD	170701	800.351.7500	www.reliancestandard.com
Flexible Spending Accounts			
WEX		866.451.3399	www.wexinc.com
Health Savings Account			
HealthEquity		877.857.6810	www.healthequity.com
401(k) Retirement Plan Adviser			
TIAA		800.842.2252	www.tiaa.org
Fidelity		800.343.0860	www.fidelity.com/atwork
Retirement Planning Portal			https://nb.fidelity.com/public/nb/scu/home
Employee Assistance Plan			
Concern	Access Code: **scueap**	800.344.4222	www.concern-eap.com
Voluntary Long Term Care			
Genworth		877.286.2852	https://scu.myltcguide.com
Back-up Care for child(ren), adults and pets			
Bright Horizons	Username: SantaClara Password: backup12		https://clients.brighthorizons.com/scu
CA 529 Plan			
Golden State ScholarShare		800.544.5248	www.scholarshare.com
Health Advocacy Services			
Health Advocate		800.695.8622	www.healthadvocate.com/members
Benefits Broker			
Marsh & McLennan Insurance Agency LLC 1340 Treat Boulevard, Suite 250 Walnut Creek, CA 94597		925.482.9300	www.MarshMMA.com

Santa Clara University's Health and Welfare Benefits Annual Notice Packet

For the January 1st 2024- December 31st, 2024

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact us at Human Resouces.

Medicare Part D
Creditable Coverage Notice
Important Notice from Santa Clara University
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Santa Clara University 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 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:

9. **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.**

10. **Santa Clara University has determined that the prescription drug coverage offered by the Aetna and Kaiser is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable 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 15th to December 7th. 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 drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in Santa Clara University coverage as an active employee, please note that your Santa Clara University coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your

Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Santa Clara University coverage as a former employee.

You may also choose to drop your Santa Clara University coverage. If you do decide to join a Medicare drug plan and drop your current Santa Clara University coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Santa Clara University and don't join a Medicare 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 the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Santa Clara University 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 Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare 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).

Name of Entity/Sender: Santa Clara University

Contact--Position/Office: Human Resources
Address: 500 El Camino Real Santa Clara, CA 95053

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Santa Clara University group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days 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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Santa Clara University sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Santa Clara University, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Santa Clara University, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Santa Clara University HIPAA Privacy Officer or :

Santa Clara University, Inc.
Attention: HIPAA Privacy Officer

500 El Camino Real
Santa Clara, CA.
95053

Effective Date

This Notice as revised is effective January 1st, 2024.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine

benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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 that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office 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 for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** 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 eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a 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. If you would like more information on WHCRA benefits, contact your plan administrator.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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 can become 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, 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.

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;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- 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;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- 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;
- 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 Human Resources.

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.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what 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 the Medicare initial enrollment period, 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.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

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/agencies/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.

APPENDIX

These are additional notices that may be appropriate based upon an employer's circumstances. We included the Surprise Billing Notice to assist with an employer's obligation to post the notice on its website (in those rare circumstances where it may be necessary).

- ☐ Medicare Part D Cross-Reference
- ☐ Medicare Part D Non-Creditable Coverage Notice
- ☐ HIPAA Privacy Notice of Availability
- ☐ ACA Grandfathered Status Notice
- ☐ HIPAA Wellness Program Reasonable Alternative Standards (RAS) Notice – Medical plans with wellness programs that offer health contingent incentives
- ☐ EEOC Wellness Program Notice
- ☐ Surprise Billing Notice – "Your Rights and Protections Against Surprise Medical Bills"

Notes

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Prepared by: Marsh & McLennan Insurance Agency LLC
www.MarshMMA.com | CA Insurance Lic: 0H18131