2018 BENEFITS INFORMATION GUIDE

Understanding your Options
HELLO!

We are pleased to provide you with our 2018 Employee Benefits Information Guide.

At Santa Clara, we are committed to providing you and your eligible dependents with a comprehensive benefits package that will meet your evolving needs. With respect to our employee benefits, our goal is to implement options, programs and resources which align with your personal health care, well-being and financial objectives.

Additionally, we aim to:

- Offer cost-effective coverage
- Provide meaningful programs and plan designs
- Maintain quality health care options
- Remain competitive with our benefits package

This year we are proud to offer a range of benefits to our employees. The Employee Benefits Information Guide can assist you in understanding your choices for coverage and resources available to you and your family. We have included an overview of each option, along with plan highlights and cost comparisons.

We recognize that benefits selections are a personal decision and that health care costs have continued to rise on a national level. With these factors in mind, we have made every effort to design a benefits package which fits your lifestyle and rewards your contribution to our company’s success. We encourage you to spend time reviewing the enclosed information in order to learn more about the benefits we are offering and appropriately select options that best suit you and your family.

Here’s to your health in 2018!
GETTING STARTED
4
4 Benefits Bird’s Eye View
5 Enrollment
7 Benefits Information on the Go

YOUR HEALTH
8
8 Medical
12 Health Savings Account (HSA)
14 Dental Plan
15 Vision Plan

LIFE & DISABILITY
16
16 Basic Life and AD&D
17 Voluntary Life
17 Business Travel Accident
18 Short & Long Term Disability

WORK/LIFE
19
19 Flexible Spending Accounts (FSA)
20 Employee Assistance Program (EAP)
21 Health Advocate
22 Mission to Wellness
23 Time Off Benefits
24 Education Benefits
25 Kids on Campus
26 Even More Coverage Options
27 SCU Retirement Plans

ADDITIONAL RESOURCES
28
28 Cost Breakdown
29 Directory & Resources

REQUIRED NOTICES
30
30 Plan Guidelines and Evidence of Coverage
31 Medicare Part D Notice
32 Legal Information Regarding Your Plans
36 The Children’s Health Insurance Program (CHIP)
36 Premium Assistance Subsidy Notice
**BENEFITS BIRD’S EYE VIEW**

At SCU, we offer a range of options to fit your lifestyle.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>PLAN OPTIONS</th>
</tr>
</thead>
</table>
| Medical                   | • Kaiser HMO Silver Plan  
                             | • Kaiser HMO Gold Plan  
                             | • Anthem Blue Cross Silver HMO Plan  
                             | • Anthem Blue Cross Gold HMO Plan  
                             | • Anthem Blue Cross Lumenos HSA PPO Plan |
| Dental                    | • Delta Dental PPO Plan                                                    |
| Vision                    | • Anthem Blue View Vision Plan                                             |
| Life & Disability         | • Anthem Basic Life and AD&D.  
                             | • Matrix Short Term Disability  
                             | • Reliance Standard Long Term Disability  
                             | • Anthem Supplemental Life and AD&D  
                             | • Business Travel Accident  
                             | • Flexible Spending Accounts (FSA)  
                             | • Health Savings Account (HSA)  
                             | • Employee Assistance Program (EAP)  
                             | • Health Advocate  
                             | • Time Off Benefits          |
ENROLLMENT

Who can Enroll?

Regular full-time employees working a minimum of 20 hours per week for the University. 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.

Children are considered eligible if they are:

- Your or your spouse’s/state registered domestic partner’s biological children, stepchildren, adopted children up to age 26 regardless of student or tax status
- Your or your spouse’s/state registered domestic partner’s children of any age if they are incapable of self-support due to a physical or mental disability

When Does Coverage Begin?

Your enrollment choices remain in effect through the end of the benefits plan year, January 2018 – December 2018. Benefits for eligible new hires will commence as outlined below:

<table>
<thead>
<tr>
<th>ELIGIBILITY DATE</th>
<th>BENEFIT PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The first day of the month coinciding with or following your date of hire (you must enroll within 30 days of becoming eligible).</td>
<td>• Medical Plan</td>
</tr>
<tr>
<td>• Immediately upon your date of hire or date of transfer to a benefit eligible position for short term disability benefit.</td>
<td>• Dental Plan</td>
</tr>
<tr>
<td></td>
<td>• Vision Plan</td>
</tr>
<tr>
<td></td>
<td>• Flexible Spending Plan (Section 125 Plan) &amp; Transit</td>
</tr>
<tr>
<td></td>
<td>• Basic Life and Accidental Death &amp; Dismemberment Insurance (AD&amp;D)</td>
</tr>
<tr>
<td></td>
<td>• Long-Term &amp; Short-Term Disability Insurance</td>
</tr>
<tr>
<td></td>
<td>• 401(a) and 403(b) Retirement Plans</td>
</tr>
<tr>
<td></td>
<td>• Voluntary Life Insurance</td>
</tr>
<tr>
<td></td>
<td>• Voluntary Long Term Care</td>
</tr>
<tr>
<td></td>
<td>• Voluntary Cancer Protection Plan</td>
</tr>
<tr>
<td></td>
<td>• EAP</td>
</tr>
</tbody>
</table>

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information. As a new hire, you will be defaulted to the Kaiser Silver plan if no election is made.

HOW DO I ENROLL?

Contact HR

- Please visit https://scu.edu/hr/staff/benefits/ for more information.
- If you have further questions, contact Human Resources.
WHAT IF MY NEEDS CHANGE DURING THE YEAR?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status 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 qualified event. Please refer to the Summary Plan Description for more details: https://scu.edu/hr/staff/benefits.

Change in status examples include:
- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse’s/registered domestic partner’s loss or gain of coverage through our organization or another employer.
- Change in employment status where you have a reduction in hours to an average below 20 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan. The plan must provide Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage.
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace (i.e. Exchange) and it 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 qualified status changes, please refer to the “Legal Information Regarding Your Plans” contents.

DO I HAVE TO ENROLL?

Most U.S. citizens and legal residents are subject to a federal tax penalty if they do not have qualifying health insurance coverage. To avoid paying the penalty, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as a State Health Insurance Exchange.

For information regarding Health Care 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 and/or dental coverage if you have access to coverage through another plan. To waive coverage, you must submit a completed Waiver of Group Coverage Form with proof of coverage to Human Resources. It is important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be January 2019 or if a qualifying status change occurs.
Anthem – On the Go!

With Anthem’s mobile app, you can:

• Find a doctor, hospital or urgent care facility.
• Login to view your personal benefits information.
• Fax or email your Mobile ID card from your smartphone or device directly to your doctor.
• Contact Anthem Customer Support directly from the app.

Search for Anthem’s mobile app in the App Store or Google Play to get started!

Kaiser Permanente – On the Go!

The KP mobile app gives you a suite of tools to use on the go! Use this application with your Kaiser Permanente user ID and password to:

• See your health history at your fingertips.
• Refill prescriptions for yourself or another member.
• Check the status of your prescription order.
• Schedule, view, and cancel appointments.
• Access your message center to email your doctor or another KP department.
• Find KP locations and facilities near you.

Search for Kaiser’s mobile app in the App Store or Google Play to get started!

Anthem LiveHealth Online

Have a health question? Under the weather? With LiveHealth Online, you don’t have to schedule an appointment, drive to the doctor’s office, and then wait for your appointment. In fact, you don’t even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed. (1)

With LiveHealth Online, you get:

• Immediate doctor visits through live video.
• Your choice of U.S. board-certified doctors.
• Help at the same cost as your regular doctor visits.
• Private, secure and convenient online visits.

Who are the doctors who use LiveHealth Online?

• U.S. board-certified.
• Average 15 years practicing medicine.
• Mostly primary care physicians.
• Specially trained for online visits.

When can you use LiveHealth Online?

As always, you should call 911 with any emergency. Otherwise, you can use LiveHealth Online whenever you have a health concern and don’t want to wait. Doctors are available 24 hours a day, seven days a week, 365 days a year. Some of the most common uses include:

• Cold and flu symptoms such as a cough, fever and headaches
• Allergies
• Sinus infections
• Family health questions

Start a conversation now.

Just enroll for free at www.livehealthonline.com or use the QR codes here to download the app, and you’re ready to see a doctor.

(1) As legally permitted in certain states
# Medical

## What are my Options?

Use the chart below to help compare medical plan options and determine which would be the best for you and your family.

<table>
<thead>
<tr>
<th>Required to select and use a Primary Care Physician (PCP)</th>
<th>HMO</th>
<th>PPO (HDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser/Anthem</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Seeing a Specialist</th>
<th>HMO</th>
<th>PPO (HDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser/Anthem</td>
<td>Referral required in most cases</td>
<td>No referral required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible Required</th>
<th>HMO</th>
<th>PPO (HDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser/Anthem</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Finding a Provider</th>
<th>HMO</th>
<th>PPO (HDHP)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Claims Process</th>
<th>HMO</th>
<th>PPO (HDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Usually handled by Kaiser or by providers if enrolled in Anthem</td>
<td></td>
<td>PPO network providers will submit claims. You submit claims for other services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Important Tips</th>
<th>HMO</th>
<th>PPO (HDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• This plan requires that you see a doctor in the specific network to receive coverage</td>
<td></td>
<td>• Although this plan has a higher deductible than most plans, it requires lower payroll deductions.</td>
</tr>
<tr>
<td>• Out-of-Network services without proper PCP referral will not be covered</td>
<td></td>
<td>• The HSA account provides a tax-favored vehicle to help you manage your out-of-pocket expenses.</td>
</tr>
<tr>
<td>• Emergencies covered worldwide</td>
<td></td>
<td>• Emergencies covered worldwide.</td>
</tr>
</tbody>
</table>

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

## PLAN HIGHLIGHTS

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>KAISER SILVER HMO</th>
<th>KAISER GOLD HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Calendar Year Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Maximum Calendar Year Out-of-pocket (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP) / Specialist Visit</td>
<td>$30 Copay / $30 Copay</td>
<td>$20 Copay / $20 Copay</td>
</tr>
<tr>
<td>Routine Physical Exam / Preventive Care</td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab</td>
<td>$10 Copay</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$15 Copay; Limited to 30 Visits per Calendar Year</td>
<td>$15 Copay; Limited to 30 Visits per Calendar Year</td>
</tr>
<tr>
<td>Optical Dispensing</td>
<td>$175 Eyewear Allowance Every 2 Years</td>
<td>$175 Eyewear Allowance Every 2 Years</td>
</tr>
<tr>
<td>Hearing Aid Benefit</td>
<td>$2,500 allowance per device; 1 device per ear; 2 devices every 3 years</td>
<td>$2,500 allowance per device; 1 device per ear; 2 devices every 3 years</td>
</tr>
<tr>
<td>Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room &amp; Board</td>
<td>$500 Copay per Day</td>
<td>$250 Copay per Admission</td>
</tr>
<tr>
<td>Maternity</td>
<td>Same as Other Illness</td>
<td>Same as Other Illness</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150 Copay</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$500 Copay per Day</td>
<td>$250 per Admission</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$30 Copay per Visit</td>
<td>$20 Copay per Visit</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive Drugs &amp; Devices</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Tier 1 (30-day supply)</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Tier 2 (30-day supply)</td>
<td>$30 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Mail Order (90-day supply)</td>
<td>2 x copay (100-day supply)</td>
<td>2 x copay (100-day supply)</td>
</tr>
</tbody>
</table>

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

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

## PLAN HIGHLIGHTS

<table>
<thead>
<tr>
<th>Plan Description</th>
<th><strong>BC SILVER HMO</strong></th>
<th><strong>BC GOLD HMO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Description</strong></td>
<td>You choose a Primary Care Physician to coordinate all of your healthcare. Services obtained from non-authorized providers will not be covered by Blue Cross.</td>
<td>You choose a Primary Care Physician to coordinate all of your healthcare. Services obtained from non-authorized providers will not be covered by Blue Cross.</td>
</tr>
<tr>
<td><strong>Annual Calendar Year Deductible</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Max Calendar Year Out-of-pocket (1)</strong></td>
<td>Individual $3,500</td>
<td>Family $7,000</td>
</tr>
<tr>
<td><strong>Maximum Calendar Year Out-of-pocket (1)</strong></td>
<td>Individual $2,000</td>
<td>Family $4,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Individual Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Professional Services</strong></td>
<td>Doctor Office Visits / Specialist Visit $30 Copay / $45 Copay</td>
<td>Doctor Office Visits / Specialist Visit $20 Copay / $40 Copay</td>
</tr>
<tr>
<td><strong>Live Health Online Visits</strong> (Doctor / Social Worker / Psychologist)</td>
<td>$30 copay / visit</td>
<td>$20 copay / visit</td>
</tr>
<tr>
<td><strong>Routine Physical Exam / Preventive Care</strong></td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray / Lab</strong></td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>$15 Copay (Chiropractor or Acupuncturist) Limited to 20 combined visits per calendar year</td>
<td>$15 Copay (Chiropractor or Acupuncturist) Limited to 20 combined visits per calendar year</td>
</tr>
<tr>
<td><strong>Hearing Aid Benefit</strong></td>
<td>Covered at 80%</td>
<td>Covered at 80%</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td>Room &amp; Board $1,000 Copay per Day up to 3 Days Max.</td>
<td>Room &amp; Board $250 Copay per Admission</td>
</tr>
<tr>
<td><strong>Maternity (delivery)</strong></td>
<td>Same as Other Illness</td>
<td>Same as other Illness</td>
</tr>
<tr>
<td><strong>Emergency Room (waived if admitted)</strong></td>
<td>$150 Copay</td>
<td>$100 Copay</td>
</tr>
<tr>
<td><strong>Mental Health / Chemical Dependency</strong></td>
<td>Inpatient $1,000 Copay per Day up to 3 Days Max.</td>
<td>Inpatient $250 per Admission</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>$30 Copay per Visit (pre-service review required)</td>
<td>$20 Copay per Visit (pre-service review required)</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Tier 1 (30-day supply) $10 Copay</td>
<td>Tier 1 (30-day supply) $10 Copay</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (30-day supply) $25 Copay</td>
<td>Tier 2 (30-day supply) $25 Copay</td>
</tr>
<tr>
<td></td>
<td>Tier 3 (30-day supply) $50 Copay</td>
<td>Tier 3 (30-day supply) $50 Copay</td>
</tr>
<tr>
<td></td>
<td>Tier 4 (30-day supply) 20% to $250 Copay</td>
<td>Tier 4 (30-day supply) 20% to $250 Copay</td>
</tr>
<tr>
<td></td>
<td>Mail Order (90-day supply) Tier 1: 2.5 x Copay Tier 2 &amp; 3: 3 x Copay Tier 4: 20% to $250 Copay (30-day supply)</td>
<td>Mail Order (90-day supply) Tier 1: 2.5 x Copay Tier 2 &amp; 3: 3 x Copay Tier 4: 20% to $250 Copay (30-day supply)</td>
</tr>
</tbody>
</table>

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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.
## ANTHEM BC PPO PLAN

### PLAN HIGHLIGHTS

**Plan Description**

This Lumenos plan allows an insured person to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan that protects the insured person against large medical expenses. Unless specifically indicated, deductible must be met to receive full plan benefits.

<table>
<thead>
<tr>
<th>Annual Calendar Year Deductible</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Individual within Family</td>
<td>$2,700</td>
<td>$5,200</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Calendar Year Out-of-pocket</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,425</td>
<td>$12,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,850</td>
<td>$24,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lifetime Maximum</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

**Professional Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Office Visits / Specialist Visit</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>LiveHealth Online Visits (Doctor / Social Worker / Psychologist)</td>
<td>$20 / $80 / $95 copay</td>
<td>10% copay after Deductible is met</td>
</tr>
<tr>
<td>Routine Physical Exam / Preventive Care</td>
<td>Covered at 100% (deductible waived)</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Diagnostic X-ray / Lab</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>Physical Therapy/Chiropractic Services</td>
<td>Covered at 90%; Limited to 30 Visits per Calendar Year</td>
<td>Covered at 70%; Limited to 30 Visits per Year</td>
</tr>
<tr>
<td>Hearing Aid Benefit</td>
<td>Covered at 80%</td>
<td>Covered at 80%</td>
</tr>
</tbody>
</table>

**Hospital Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board</td>
<td>Covered at 90%</td>
<td>Covered at 70% limited to $1,000 per day for non-emergency admission</td>
</tr>
<tr>
<td>Maternity (delivery)</td>
<td>Covered at 90%</td>
<td>Covered at 70% limited to $1,000 per day for non-emergency admission</td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>Covered at 90%</td>
<td>Covered at 90%</td>
</tr>
<tr>
<td>Mental Health / Chemical Dependency</td>
<td>Covered at 90%</td>
<td>Covered at 70% limited to $1,000 per day for non-emergency admission</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Covered at 90%</td>
<td>Covered at 70% limited to $350 per visit</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Covered at 90%</td>
<td>Covered at 70%</td>
</tr>
</tbody>
</table>

**Prescription Drugs**

<table>
<thead>
<tr>
<th>Tier</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (30-day supply)</td>
<td>$10 Copay</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>2 (30-day supply)</td>
<td>$40 Copay</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>3 (30-day supply)</td>
<td>$60 Copay</td>
<td>Covered at 70%</td>
</tr>
<tr>
<td>4 (30-day supply)</td>
<td>30% to $250 Copay</td>
<td>Covered at 70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order (90-day supply)</th>
<th>Tier 1: 2.5 x Copay</th>
<th>Tier 2 &amp; 3: 3 x Copay</th>
<th>Tier 4: 30% to $250 Copay</th>
</tr>
</thead>
</table>

---

(1) Employees enrolling in the HSA (compatible) High Deductible PPO plan are eligible to establish and contribute to a Health Savings Account (HSA). More can be learned about HSAs by contacting Blue Cross www.bluecrossca.com

(2) PPO network reimbursement based on negotiated fees, Non-PPO network reimbursement based on reasonable & customary fees

(3) 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.
HEALTH SAVINGS ACCOUNT (HSA)

What is it?
By enrolling in the Anthem Blue Cross Lumenos HSA 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 health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What are the benefits?
Administered by Benefit Wallet, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return.
- HSA funds can grow on a tax-free basis, subject to state law.
- A HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no “Use it or Lose it” provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses.
- You may enjoy lower monthly premium payments as compared to traditional PPO medical plans.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.

How do I qualify for an HSA?
The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified HDHP.
- You are not enrolled in non-qualified health insurance outside of your HDHP.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else’s tax return.
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

How do I get started?
Account activation may be completed electronically at https://mybenefitwallet.com. Click on the Register button in the Member Log In area. From the Account Summary page click the Activate Your HSA link and follow the prompts. Electronic activation Instructions will also be included in the Welcome Kit that will be mailed to your home. You may also open your account by submitting the Master Signature Card included in the Welcome Kit. Even if you provide your signature electronically, please complete and return the Master Signature Card.

Since your HSA is a bank account, personal information is requested during activation as required by federal banking regulations under the Patriot Act, just as it would be required to open a traditional banking account. Consult your tax advisor for taxation information or advice.

12.
Santa Clara University 2018 Benefits Information Guide
HEALTH SAVINGS ACCOUNT (HSA) - CONTINUED

HSA Funds and State Registered Domestic Partnerships

- The HSA is a federal program that does not recognize state registered domestic partnerships even if the state of residency does. Therefore, although you may cover your state registered domestic partner (and their children) on the Anthem’s HDHP, employer contributions for your state registered domestic partner (and their children) will be reported as imputed income on your Form W-2 and taxed. In addition, any premium contributions you make for the state registered domestic partner’s coverage will be taken post-tax.

- Further, unless your state registered domestic partner qualifies as a legal tax dependent under IRC 152 and is claimed as your spouse on your joint tax return, you cannot use your HSA funds for their expenses (even if qualified) without being taxed the additional 20% penalty.

HSA and Medicare

- Employees over age 65 are eligible to open and contribute to an HSA as long as they are not enrolled in benefits under Medicare and are covered by a qualified HDHP. Once enrolled in Medicare, you are still eligible to be covered by the qualified HDHP, but you are no longer eligible for HSA contributions.

- After the account holder turns 65 or enrolls in Medicare, the tax penalty for non-eligible expenses does not apply, so your HSA can be used to save for retirement, but distributions are still treated as gross income for tax purposes.

A few rules you need to know:

- In 2018, the maximum contribution limit is $3,450 if you are enrolled in the HSA-PPO for employee-only coverage and $6,900 for employees with dependent coverage.

- Those over age 55 can contribute an additional $1,000 annually.

- 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 health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit https://www.irs.gov/pub/irs-pdf/p502.pdf.

- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.

- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse’s non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met.

- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a pro-rata portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

How do I manage my HSA?

- 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
- View the status of your claims and check your HSA balance at https://mybenefitwallet.com.
# DENTAL PLAN

## Your Dental PPO Plan

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental.

## Using the 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 view a complete plan summary, visit [www.deltadentalins.com](http://www.deltadentalins.com).

## PLAN HIGHLIGHTS

<table>
<thead>
<tr>
<th>General Information</th>
<th>In-Network</th>
<th>Out-of-Network(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible (waived for Preventative)</strong></td>
<td><strong>$25</strong></td>
<td><strong>$25</strong></td>
</tr>
<tr>
<td>Individual</td>
<td><strong>$25</strong></td>
<td><strong>$25</strong></td>
</tr>
<tr>
<td>Family</td>
<td><strong>$75</strong></td>
<td><strong>$75</strong></td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td><strong>$2,500</strong></td>
<td><strong>$2,500</strong></td>
</tr>
<tr>
<td>Preventive (x-rays, cleanings, exams)</td>
<td>Eligible Charges Covered at 100%</td>
<td>Eligible Charges Covered at 100%</td>
</tr>
<tr>
<td>Basic Services (amalgam fillings, extractions, root canals)</td>
<td>Eligible Charges Covered at 100%</td>
<td>Eligible Charges Covered at 80%</td>
</tr>
<tr>
<td>Major Services (bridges, dentures, crowns, implants)</td>
<td>Eligible Charges Covered at 60%</td>
<td>Eligible Charges Covered at 50%</td>
</tr>
<tr>
<td>Orthodontia Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee &amp; Children up to age 26</td>
<td>Eligible Charges Covered at 50%</td>
<td>Eligible Charges Covered at 50%</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td><strong>$3,000</strong></td>
<td><strong>$3,000</strong></td>
</tr>
</tbody>
</table>

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

(1) Payment to provider based on reasonable and customary rates

## Find your Favorite Dentist

When using a Dental PPO plan, you can receive services from dental providers both in and out of your insurance network. However, you’ll receive better coverage when you use an in-network dentist. To determine whether your dentist is in or out of your insurance network, go to [www.deltadentalins.com](http://www.deltadentalins.com) or call (800) 765-6003.
VISION PLAN

Your Vision Plan

Vision coverage is offered by Anthem Blue View as a Preferred Provider Organization (PPO) plan.

Using the 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 view a complete plan summary, visit www.anthem.com/ca.

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**PLAN HIGHLIGHTS**

<table>
<thead>
<tr>
<th>General Plan Information</th>
<th>In-Network</th>
<th>Out-of-Network&lt;sup&gt;(1)&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam – Every 12 months</td>
<td>$20</td>
<td>$45</td>
</tr>
<tr>
<td>Lenses – Every 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>Covered at 100%</td>
<td>$45</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Covered at 100%</td>
<td>$65</td>
</tr>
<tr>
<td>Trifocal</td>
<td>Covered at 100%</td>
<td>$85</td>
</tr>
<tr>
<td>Progressive</td>
<td>Covered at 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Frames – Every 12 months</td>
<td>Covered at 100% up to $120</td>
<td>Covered to a Max. of $47</td>
</tr>
<tr>
<td>Contacts – Every 12 months, in lieu of lenses &amp; frames</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Covered at 100%</td>
<td>Covered to a Max. of $210</td>
</tr>
<tr>
<td>Cosmetic</td>
<td>Covered to a Max. of $120</td>
<td>Covered to a Max. of $105</td>
</tr>
</tbody>
</table>

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

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<sup>(1)</sup> Payment to provider based on reasonable and customary rates

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**ANTHEM BLUE VIEW VISION PPO**

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**Five Tips for Superior Vision**

Don’t take your eyes for granted! The following pointers can help you keep your vision strong:

- Eat lots of leafy greens and dark berries.
- Get regular eye exams.
- Give your eyes a rest from staring into the computer screen.
- Wear sunglasses to protect your eyes from bright light.
- Wear safety eyewear whenever necessary.
BASIC LIFE AND AD&D

Protect your loved ones

In the event of your death, 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. For additional information please visit: https://scu.edu/hr/staff/benefits/

Your coverage

Paid for in full by SCU, the benefits outlined below are provided by Anthem Blue Cross:

- Basic Life Insurance amount of $70,000.
- AD&D amount of $70,000.

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 a Resource Advisor (888.209.7840).

Counseling: Legal, financial and grief counseling

Online services and tools: Wills, living wills, legal library, financial calculators and web resources

Work/life resources: Child care, elder care, college locators

Identity theft victim recovery services: Unlimited fraud resolution and recovery services and 12 months of identity monitoring

Beneficiary Companion: Assists with immediate tasks so they can focus on the grieving process: i.e., death certificates, notifying 3rd parties, closing accounts

Healing Book: Free for children affected by the death of their loved one - helps them deal with loss

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, contact Human Resources.
**VOLUNTARY LIFE INSURANCE**

If you would like to supplement your employer paid insurance, additional Life coverage for you and/or your dependents is available for purchase on a payroll deduction basis through Anthem Blue Cross.

- **For employees:** Increments of one, two, three, four or five times your annual earnings to a maximum of $500,000 with a guarantee issue benefit of $100,000 or 3x salary (whichever is less) if you enroll in the plan within 30 days of your initial eligibility. All other employees are required to provide EOI regardless of coverage amount.
- **For your spouse:** An amount of 50% of the Employee’s benefit to up to $100,000 maximum. Spouse benefits end at age 70.
- **For your child(ren):** Over 6 months of age in increments of $2,000 up to a maximum of $10,000; 15 days old up to 6 months of age, flat $500.

For the employee, there is no age reduction, but for a spouse, benefits end at age 70. If chosen benefits exceed a certain amount, an Evidence of Insurability form must be approved by Anthem Blue Cross for benefits to be received in full. For additional information please visit: [https://scu.edu/hr/staff/benefits/](https://scu.edu/hr/staff/benefits/)

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

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

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

**BUSINESS TRAVEL ACCIDENT**

In the event of your accidental death due to traveling on SCU business, your beneficiary will receive a benefit amount equal to $100,000. Partial benefits are payable to you if you lose your eyesight or a limb as the result of an accident. For additional information please visit: [https://scu.edu/hr/staff/benefits/](https://scu.edu/hr/staff/benefits/)
**SHORT & LONG TERM DISABILITY**

**Added protection**

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.

For questions regarding your Short Term Disability coverage, call Matrix at 877.202.0055 or visit [www.matrixabsence.com](http://www.matrixabsence.com). For questions regarding Long Term Disability, call Reliance Standard at 800.351.7500 or visit [www.reliancestandard.com](http://www.reliancestandard.com).

### YOUR PLANS

**Short Term Disability (STD)**
- Administered by Matrix, STD coverage provides a benefit equal to 60% of your earnings, up to $1,300 per week for a period up to 52 weeks.
- The plan begins paying these benefits at the time of disability/after you have been absent from work for 7 consecutive days.
- For additional information please visit: [https://scu.edu/hr/quick-links/staff-policy-manual/policy-603---short-term-disability-benefits/](https://scu.edu/hr/quick-links/staff-policy-manual/policy-603---short-term-disability-benefits/)

**Long Term Disability Coverage (LTD)**
- If your disability extends beyond 360 days, the LTD coverage through Reliance Standard can replace 66 2/3% of your earnings, up to maximum of $15,000 per month.
- Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.
- For additional information please visit: [https://scu.edu/hr/quick-links/staff-policy-manual/policy-604---long-term-disability/](https://scu.edu/hr/quick-links/staff-policy-manual/policy-604---long-term-disability/)

### Disability Facts and Figures

- One in every 7 people will become disabled for five years or more in their lifetime.
- 30% of people use disability coverage.
- Nearly half (46%) of all foreclosures are caused by financial hardship due to a disability.

Source: [www.affordableinsuranceprotection.com/disability_facts](http://www.affordableinsuranceprotection.com/disability_facts)

### Tax considerations

Because the short term disability coverage is an employee paid benefit, any disability payments made to you will not be taxable. The long term disability coverage is an employer paid benefit and is available for employees at no cost; any disability payments made to you will be taxable.

**Please note:** Consult your tax advisor for additional taxation information or advice.
FLEXIBLE SPENDING ACCOUNTS (FSA)

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

<table>
<thead>
<tr>
<th>FSA TYPE</th>
<th>DETAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care FSA</td>
<td>• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance.</td>
</tr>
<tr>
<td></td>
<td>• Minimum contribution for 2018 is $300.</td>
</tr>
<tr>
<td></td>
<td>• Maximum contribution for 2018 is $2,650.</td>
</tr>
<tr>
<td>Limited Purpose FSA</td>
<td>• Option for employees enrolled in a Health Savings Account (HSA) eligible plan.</td>
</tr>
<tr>
<td></td>
<td>• Use this FSA to reimburse for eligible preventive care, dental and vision expenses.</td>
</tr>
<tr>
<td></td>
<td>• Minimum contribution for 2018 is $300.</td>
</tr>
<tr>
<td></td>
<td>• Maximum contribution for 2018 is $2,650.</td>
</tr>
<tr>
<td>Dependent Care FSA</td>
<td>• Can be used to pay for qualified child care and/or caregivers for a disabled family member in the household, who is unable to care for themselves.</td>
</tr>
<tr>
<td></td>
<td>• Minimum contribution for 2018 is $600.</td>
</tr>
<tr>
<td></td>
<td>• Maximum contribution for 2018 is $5,000.</td>
</tr>
<tr>
<td>Commuter Spending Account</td>
<td>• Can be used to cover transit passes, payments for transportation in a commuter highway vehicle.</td>
</tr>
<tr>
<td></td>
<td>• Transit maximum contribution for 2018 is $260 per month.</td>
</tr>
</tbody>
</table>

What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit www.cbiz.com to access CBIZ’s online portal.

A few rules you need to know:

- You may carryover up to $500 from your 2017 health FSA to the 2018 plan year
- Although the plan year runs from January 2018 through December 2018, the plan allows an annual run-out period through March 31st, 2019 allowing you to seek reimbursement for any expenses incurred during the plan year (from January 1st, 2018 to December 31st, 2018).

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

How to Use Your Flexible Spending Account

- Determine your estimated healthcare usage
- Set up (pre-tax) deductions from your paycheck
- Use FSA debit card or turn in receipts for eligible expenses
- Up to $500 of FSA funds can roll over to the next year
EMPLOYEE ASSISTANCE PROGRAM (EAP)

SCU understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Provided by Santa Clara University, the Employee Assistance Program (EAP) is available to all employees and your dependents, as well as any member of your household. If you or a family member needs assistance balancing life’s demands, or require help with personal or family issues, you can contact Concern EAP for help. The Employee Assistance Program (EAP) is a confidential service that uses short-term counseling and referrals (8 consultations per incident per 12 consecutive month period) to help you deal with a variety of issues.

For additional information please visit: https://scu.edu/hr/maintain-benefits-info/employee-assistance/

<table>
<thead>
<tr>
<th>PROGRAM COMPONENT</th>
<th>COVERAGE DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Can Utilize</td>
<td>All employees, dependents of employees, and members of your household</td>
</tr>
<tr>
<td>Topics May Include</td>
<td>• Childcare.</td>
</tr>
<tr>
<td></td>
<td>• Eldercare.</td>
</tr>
<tr>
<td></td>
<td>• Legal services.</td>
</tr>
<tr>
<td></td>
<td>• Identity theft.</td>
</tr>
<tr>
<td></td>
<td>• Marital, relationship or family problems.</td>
</tr>
<tr>
<td></td>
<td>• Bereavement or grief counseling.</td>
</tr>
<tr>
<td></td>
<td>• Substance abuse and recovery.</td>
</tr>
<tr>
<td></td>
<td>• Financial support.</td>
</tr>
<tr>
<td></td>
<td>• Consumer information.</td>
</tr>
<tr>
<td>Number of Sessions</td>
<td>8 face-to-face sessions per 12 consecutive month period per member per incident</td>
</tr>
</tbody>
</table>

How to Access:
- By Phone: 800.344.4222
- Online: www.concern-eap.com
- Website password: scueap
HEALTH ADVOCATE

To assist you and your family in navigating the health care system and maximizing your benefits, the services offered by Health Advocate can assist with clinical and administrative issues, involving medical, hospital, vision, dental, pharmacy claims and other health care needs. Health Advocacy is available to eligible employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Health Advocate can help you:

- Find the right doctors, dentists, specialists and other providers
- Schedule appointments; arrange for treatments and tests
- Answer questions about test results, treatments and medications
- Clarify benefits; uncover billing errors
- Get to the bottom of coverage denials
- Get appropriate approvals for covered services
- Find options for non-covered services
- Negotiate payment arrangements with providers
- Provide information about generic drug options
- Find in-home care, adult day care, assisted living and long-term care
- Clarify Medicare, Medicare Supplement plans and Medicaid
- Research transportation to appointments

866.695.8622
Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/members
Why Wellness?
Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. We care about your total well-being and encourage all employees to engage in our Wellness Program at no-cost.

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

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

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:

<table>
<thead>
<tr>
<th>2018 Holiday</th>
<th>Date Observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Year’s Day</td>
<td>Monday, January 1</td>
</tr>
<tr>
<td>Martin Luther King, Jr. Day</td>
<td>Monday, January 15</td>
</tr>
<tr>
<td>President’s Day</td>
<td>Monday, February 19</td>
</tr>
<tr>
<td>Good Friday</td>
<td>Friday, March 30</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>Monday, May 28</td>
</tr>
<tr>
<td>Independence Day</td>
<td>Wednesday, July 4</td>
</tr>
<tr>
<td>Labor Day</td>
<td>Monday, September 3</td>
</tr>
<tr>
<td>Thanksgiving Day</td>
<td>Thursday, November 22</td>
</tr>
<tr>
<td>Day after Thanksgiving</td>
<td>Friday, November 23</td>
</tr>
<tr>
<td>Christmas Eve</td>
<td>Monday, December 24</td>
</tr>
<tr>
<td>Christmas Day</td>
<td>Tuesday, December 25</td>
</tr>
<tr>
<td>New Year’s Eve</td>
<td>Monday, December 31</td>
</tr>
</tbody>
</table>

Paid Family Leave Benefits

Santa Clara University provides Paid Family Leave Insurance (PFL) administered by Matrix Absence Management. All employees are required to make contributions in an amount equal or less than the contribution rate established by the California Employment Development Department for the California State PFL Plan each year. This plan provides wage replacement to those on an approved leave of absence to care for a spouse, state registered domestic partner, child, or parent with a serious health condition, or to bond with a newborn within the first year of life or a child within the first year following adoption or foster care placement.

The plan pays 60% of your base monthly earnings to a maximum weekly benefit of $1,300 and a minimum of $50 for up to 6 weeks. This includes the 7 calendar day waiting period.

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

This Section of Benefits Apply to Staff Only

Sick Leave

The University’s sick leave 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 Pay

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

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

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

Tuition Remission

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

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

Tuition Reimbursement

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

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

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

FACHEX

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

Tuition Exchange

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

About KOC

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

General Enrollment Information

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

Enrollment is offered in the following order of priority and is only available to children of benefits-eligible faculty and staff:

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

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

Long Term Care (LTC) Employee Paid Post Tax Benefit Plan
Santa Clara University provides group voluntary Long-Term Care through Genworth. This is an insurance program designed to provide benefits to assist with the cost of Nursing Home and/or Community Based Care required because an insured has a qualified impairment. Please see plan materials for details.
For additional information please visit: https://scu.edu/hr/staff/benefits/ or call Genworth at (800) 416-3624 or visit www.genworth.com/, using Group ID: santaclara and Access Code: groupltc

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 free gym membership to the Pat Malley Fitness Center, passes to some Athletic events, and 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 with Joe Crowley. Joe Crowley is an independent financial counselor who is available to meet with faculty and staff. He offers 50 minute, confidential appointments to assist you in making wise financial decisions from buying a home or investing in the stock market to money market accounts and other investment options. To schedule an appointment, please contact the HR Service Desk at extension 4392.
We encourage you to visit our website at: www.scu.edu to explore all the benefits of working at Santa Clara University!
SCU RETIREMENT PLANS

Whether you’re just a few years away from retirement or you’re in the early planning stages for your future, Santa Clara University offers choices to help you live comfortably at your desired retirement age.

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

- 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.
- Choose either Fidelity Investments or TIAA as your fund sponsor for this plan. Fidelity and TIAA Investments has over 60 investment options. Please see fund performance and prospectus of the appropriate plan sponsor for details.
- Employees who have worked 1000 hours per calendar year in 2 consecutive calendar years and who meet eligibility requirements in accordance with the University Retirement Plan Document.

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 or a percentage of salary. You can contribute any amount you wish up to the IRS calendar year limits.
- Choose either Fidelity Investments or TIAA as your fund sponsor for this plan. Fidelity and TIAA Investments over 60 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

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/

Your Target Retirement

Are you wondering how much you should save for retirement? Learn more by accessing a free retirement planning calculator at http://www.mmaretirement.com/calculators.cfm

Marsh & McLennan Insurance Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.
### COST BREAKDOWN

The rates below are effective January 1st, 2018 – December 31st, 2018.

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<thead>
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<th>COVERAGE LEVEL</th>
<th>EMPLOYEE CONTRIBUTION</th>
<th>SCU CONTRIBUTION</th>
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<td>Per Pay Period</td>
<td>Per Pay Period</td>
<td>Per Pay Period</td>
<td>Per Month</td>
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<td>Kaiser Permanente – Gold Option</td>
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</table>
Below, please find important contact information and resources for SCU.

<table>
<thead>
<tr>
<th>INFORMATION REGARDING</th>
<th>CONTACT</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Coverage</td>
<td>HMO Member Services</td>
<td>(800) 227-3771</td>
</tr>
<tr>
<td>Anthem Blue Cross</td>
<td>PPO Member Services</td>
<td>(800) 888-8288</td>
</tr>
<tr>
<td>Kaiser</td>
<td>HMO Member Services</td>
<td>(800) 464-4000</td>
</tr>
<tr>
<td>Dental Coverage</td>
<td>Member Services</td>
<td>(888) 335-8227</td>
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<tr>
<td>Delta Dental</td>
<td></td>
<td>(800) 464-4000</td>
</tr>
<tr>
<td>Vision Coverage</td>
<td>Member Services</td>
<td>(866) 723-0515</td>
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<tr>
<td>Anthem Blue View Vision</td>
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<td>(888) 231-5032</td>
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<tr>
<td>Life, AD&amp;D and Disability</td>
<td>Life, AD&amp;D &amp; Voluntary Life</td>
<td>(800) 815-3023</td>
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<td>Anthem Blue Cross</td>
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<td>(877) 202-0055</td>
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<tr>
<td>Reliance Standard</td>
<td>Long Term Disability</td>
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<tr>
<td>Flexible Spending Accounts</td>
<td>Flexible Spending Account, Transit, &amp;</td>
<td>(877) 472-4200</td>
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<tr>
<td>CBIZ</td>
<td>COBRA Administration</td>
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<tr>
<td>Health Savings Account</td>
<td>HSA Administrator</td>
<td>(800) 416-3624</td>
</tr>
<tr>
<td>Retirement Plans</td>
<td>TIAA Fidelity</td>
<td>(800) 842-2776</td>
</tr>
<tr>
<td>401(a) &amp; 403(b)</td>
<td></td>
<td>(800) 343-0860</td>
</tr>
<tr>
<td>Employee Assistance Plan</td>
<td>Member Services access code: scueap</td>
<td>(800) 344-4222</td>
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<td>Concern</td>
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<td>Voluntary Long-Term Care</td>
<td>Member Services</td>
<td>(800) 842-2776</td>
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<td>Genworth</td>
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<td>(800) 365-8306 x310</td>
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<td>Voluntary Cancer Plan</td>
<td>Member Services</td>
<td>(800) 343-0860</td>
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<td>American Fidelity</td>
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<tr>
<td>CA 529 Plan</td>
<td>Member Services</td>
<td>(800) 416-3624</td>
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<td>Golden State ScholarShare</td>
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<td>(800) 842-2776</td>
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<td>Health Advocacy Services</td>
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<td>(800) 343-0860</td>
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<td>Health Advocate</td>
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<td>(800) 416-3624</td>
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<tr>
<td>Benefits Broker</td>
<td>Insurance Broker</td>
<td>(925) 482-9300</td>
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<tr>
<td>Marsh &amp; McLennan Insurance</td>
<td></td>
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</tr>
<tr>
<td>Agency LLC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1340 Treat Boulevard, Suite 250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walnut Creek, CA 94597</td>
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</table>
PLAN GUIDELINES AND EVIDENCE OF COVERAGE

The benefit summaries listed on the previous 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.
MEDICARE PART D NOTICE

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure (for use on or after 04/01/2011)

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

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

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

2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered 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 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
LEGAL INFORMATION REGARDING YOUR PLANS

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

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

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

Your plans comply with these requirements.

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

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

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

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

“HIPAA Special Enrollment Opportunities” include:
- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage (3)
- Acquisition of a new spouse or dependent through marriage (4), adoption (5), or birth (6)
- Loss of state Children’s Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) (1)
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

“Change in Status” Permitted Midyear Election Changes
- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved “change in status” as defined by the IRS.
- Examples of permitted “change in status” events include:
  - Legal marital status change (e.g., marriage (7), divorce or legal separation)
  - Change in number of dependents (e.g., birth (8), adoption (8), or death)
  - Change in eligibility of a child
  - Change in your/your spouse’s/your registered domestic partner’s employment status (e.g., reduction in hours affecting eligibility or change in employment)
  - A substantial change in your/your spouse’s/your registered domestic partner’s benefits coverage
  - A relocation that impacts network access
  - Enrollment in a state-based insurance Exchange
  - Medicare Part A or B enrollment
  - Qualified Medical Child Support Order or other judicial decree
- A dependent’s eligibility ceases resulting in a loss of coverage (9)
- Loss of other coverage (9)
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e., Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the followings which require notice within 60 days:
- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

Important Information on how Health Care Reform Affects Your Plan

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

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

For plans and issuers that require or allow for the designation of a primary care provider for a child:
- For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:
- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services. If you are following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

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

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

Prohibition on Excess Waiting Periods
Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60 days.

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

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage 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 premium and know you’re 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.

(1) Indicates that this event is also a qualified “Change in Status”
(2) Indicates this event is also a HIPAA Special Enrollment Right
(3) Indicates that this event is also a qualified “Change in Status”
Continuation Coverage Rights under COBRA (continued)

What is COBRA continuation coverage?
COBRA continuation coverage is the same coverage that the plan gives to other participants or beneficiaries who aren’t getting continuation coverage. Each “qualified beneficiary” described below who elects COBRA continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

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 (choose and enter appropriate information: must pay or aren’t required to 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); or
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to (enter name of employer sponsoring the Plan) and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both);
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- 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); or
- The parents become divorced or legally separated;
- The child stops being eligible for coverage under the Plan as a “dependent child.”

How is COBRA continuation coverage provided?

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

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

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

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

How is COBRA continuation coverage provided? (Continued)

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified in a timely fashion.

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); is granted divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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.

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

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

Plan contact information

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

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

Employee Rights & Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement
Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

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

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is:

1. A current member of the Armed Forces, including a member of the National Guard or Reserves, who is serving on active duty. A covered service member is:
2. A veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy, or is otherwise in need of care.

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

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

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

(1) The FMLA definitions of “serious injury or illness” for current servicemembers and veterans are distinct from the FMLA definition of “serious health condition”
(2) Special hours of service eligibility requirements apply to airline flight crew employees
Definition of Serious Health Condition

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

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

Use of Leave

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

Substitution of Paid Leave for Unpaid Leave

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

Employee Responsibilities

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

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include the name of the employee; the reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

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

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

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

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

Enforcement

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

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

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

For additional information: (866) 4US-WAGE (866) 487-9243 TTY: (877) 889-5627 www.dol.gov/whd
Notice of Health Information Privacy Practices

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

This notice is EFFECTIVE: 1/1/2018

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

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

Required by Law

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

Permitted Plan use of Your Health Information

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

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

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

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

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

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

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

Attest to the maintenance of the confidentiality of your PHI. The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. We will follow the terms of this notice with respect to information we collect and maintain about you and you provide us a copy of the notice.

Abide by the terms of this notice.

Notify you if we are unable to agree to a requested restriction, amendment or other request.

Notify you of any breaches of the protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).

Acommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose “summary health information” to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

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

Your Right to File a Complaint

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

Changes to the Terms of This Notice

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

Contact Person

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

Human Resources
THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)
PREMIUM ASSISTANCE SUBSIDY NOTICE

Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP you are eligible for premium subsidy assistance programs 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, you can contact your State Medicaid or CHIP office or dial (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 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.askelba.dol.gov or call (866) 444-4EBSA (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 August 10, 2017. Contact your State for more information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Phone</th>
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<th>Website</th>
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<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: <a href="http://www.myalhccp.com">www.myalhccp.com</a></td>
<td>Phone: (855) 692-5447</td>
<td>(866) 444-4EBSA (3272)</td>
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<tr>
<td>ALASKA – Medicaid</td>
<td>Website: myalhccp.com</td>
<td>Phone: 1-(866) 251-4861</td>
<td>Email: <a href="mailto:customerservices@myalhccp.com">customerservices@myalhccp.com</a></td>
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<tr>
<td>ARKANSAS – Medicaid</td>
<td>Website: myarhccp.com</td>
<td>Phone: 1-855-MYARHCCP (855-692-7447)</td>
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<tr>
<td>COLORADO – Medicaid</td>
<td>Website: myalhccp.com</td>
<td>Phone: 1-(866) 251-4861</td>
<td>Email: <a href="mailto:customerservices@myalhccp.com">customerservices@myalhccp.com</a></td>
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<tr>
<td>FLORIDA – Medicaid</td>
<td>Website: <a href="http://www.flmedicaidhelprecovery.com/hpp">www.flmedicaidhelprecovery.com/hpp</a></td>
<td>Phone: (877) 357-3268</td>
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<td>GEORGIA – Medicaid</td>
<td>Website: <a href="https://dhr.georgia.gov/medicaid">https://dhr.georgia.gov/medicaid</a></td>
<td>Phone: (404) 686-4507</td>
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<td>INDIANA – Medicaid</td>
<td>Medicaid Website: dhs.in.gov</td>
<td>Phone: (800) 432-7632</td>
<td>Lincoln: (402) 473-7000</td>
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<td>MASSACHUSETTS – Medicaid and CHIP</td>
<td>Website: <a href="https://mass.gov/eholsgov/departments/masshealth/">https://mass.gov/eholsgov/departments/masshealth/</a></td>
<td>Phone: (800) 862-4840</td>
<td>Omaha: (402) 595-1178</td>
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<tr>
<td>NEBRASKA – Medicaid</td>
<td>Website: <a href="https://www@dss.ne.gov/medicaid">https://www@dss.ne.gov/medicaid</a></td>
<td>Phone: (800) 992-0900</td>
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<td>NEW HAMPSHIRE – Medicaid</td>
<td>Website: <a href="http://www.dhhs.nh.gov/ei/documents/hippapp.pdf">www.dhhs.nh.gov/ei/documents/hippapp.pdf</a></td>
<td>Phone: (603) 271-5218</td>
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<td>SOUTH CAROLINA – Medicaid</td>
<td>Website: <a href="http://www.scdhhs.gov/index.html">http://www.scdhhs.gov/index.html</a></td>
<td>Phone: (800) 432-5924</td>
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<tr>
<td>SOUTH DAKOTA – Medicaid</td>
<td>Website: <a href="https://www.mywvhipp.com">https://www.mywvhipp.com</a></td>
<td>Phone: (888) 628-0059</td>
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<td>TEXAS – Medicaid</td>
<td>Medicaid Website: <a href="https://www.getthepx.com/">https://www.getthepx.com/</a></td>
<td>Phone: (800) 440-0493</td>
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<td>VERMONT – Medicaid</td>
<td>Medicaid Website: health.utah.gov/medicaid</td>
<td>Phone: (800) 250-8427</td>
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<td>WISCONSIN – Medicaid</td>
<td>Medicaid Website: health.wa.gov/central_wa</td>
<td>Phone: (855) 242-8282</td>
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<td>WYOMING – Medicaid</td>
<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>Phone: (800) 432-5924</td>
<td>CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>CHIP Phone: (800) 692-7462</td>
</tr>
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</table>

To see if any other States have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
(307) 777-7551

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
(877) 267-2333, Menu Option 4, ext. 61565

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