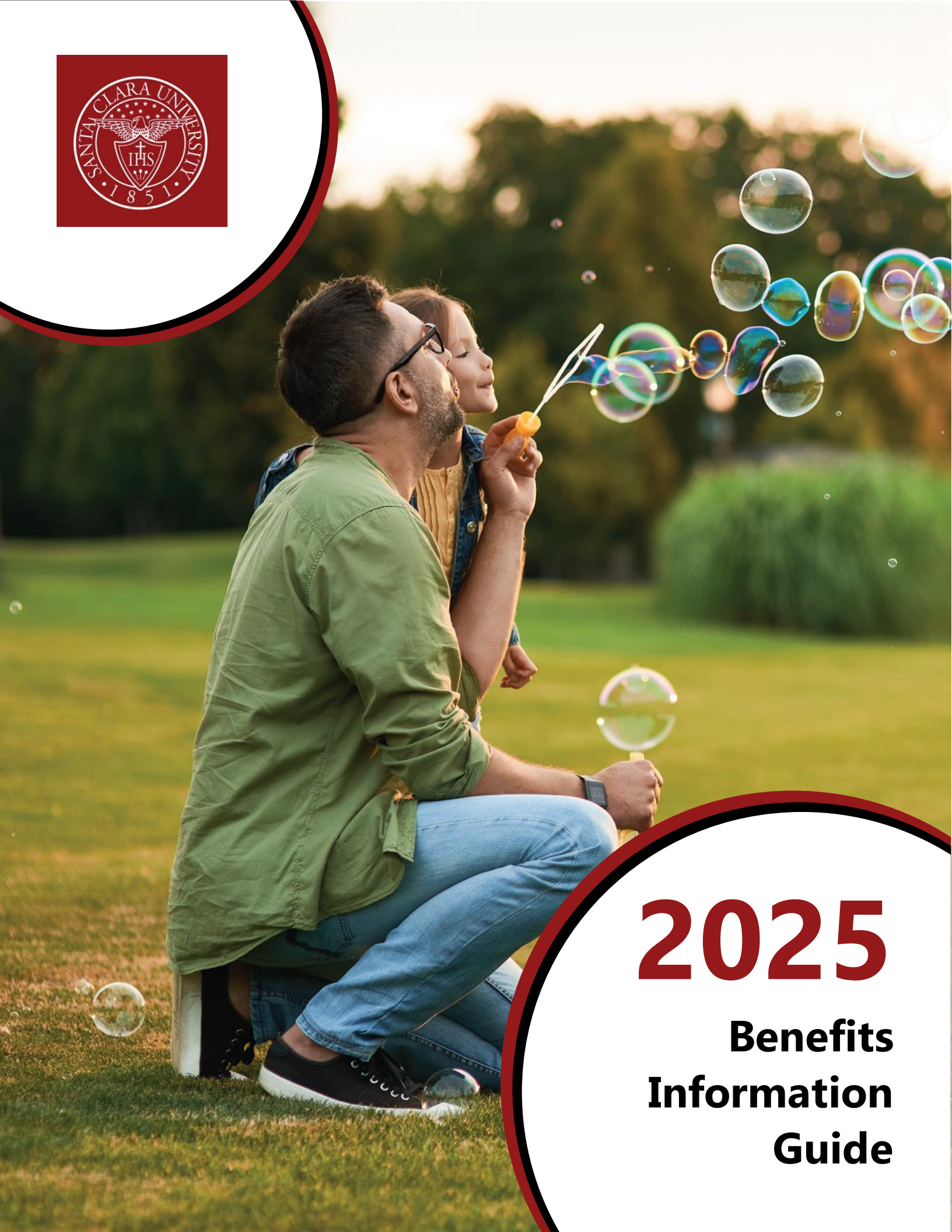


2025

Benefits Information Guide

Welcome to 2025 Open Enrollment!

Santa Clara University offers comprehensive health care and insurance benefits designed to promote and sustain good health for you and your family, help cushion financial obligations associated with illness, and assist in building a retirement income. One of the best ways that you can protect your physical, mental, and financial health is by enrolling in the right plans and making the most of your University benefits. At Santa Clara, we recognize the important role your benefits play in helping you and your family thrive and plan for the future. We offer a competitive, high-quality benefits package designed to support and advance your overall well-being.

As our annual Open Enrollment period begins, we ask that you and your family look at your current elections and ask yourself:

- Am I enrolled in the right medical plan for myself/my family?
- Am I taking advantage of pre-tax opportunities to offset medical, dental, and vision expenses?
- Are there voluntary insurance programs I could take advantage of to protect my family and myself in the case of injury or illness?
- Do I need to update my beneficiary contact information?

To learn more about the available 2025 benefits options, please join us during the month of November for information sessions and the annual Mission to Wellness Benefits Expo. Additional information about these events can be found at *https://www.scu.edu/hr/benefits/open_enrollment/*. For more customized benefits enrollment support, ALEX *(https://start.myalex.com/santa-clara-university)* provides interactive decision support, designed to make the benefits election process less complicated and more tailored to your needs. The Benefits Team remains available to support you through this process, and to answer any questions that you may have.

Take Action

Open Enrollment will begin on **Tuesday, November 5 and run through Friday, November 22**. This is your opportunity to review your current benefits, make adjustments, and select the best options for your needs in the upcoming year. Once the enrollment period ends on **Friday, November 22**, you won't be able to adjust your benefits unless you experience a qualifying life event.

Zenobia Lane
Vice President, Human Resources

Welcome

Your time with your team is important, but there's more to life than work. The benefits you'll find here are carefully chosen to support your life outside of work, whatever it looks like for you. Whether you're checking it out for the first time or stopping by for a visit, this guide is crafted to help you choose the right benefits. We'll talk about medical, dental, spending accounts, retirement, and more.

We'll also help you put those benefits to use whenever you need them throughout the plan year. You'll find answers to important questions like "How do I add my new kid to my insurance?" or "How much vacation time do I get, again?"

Grab a cup of coffee or tea, and let's get started.

Plan summary

Does this guide contain everything I need to know about my health plan?

While there are many brief benefit summaries listed throughout this guide, they're just that: summaries. When you're trying to figure out whether a medical service or a medical supply will be paid for by your health plan, it's best to take a look at the Evidence of Coverage or Summary Plan Description as well.

One important thing to note is that in order for a service or supply to be paid for by your health plan, it must be overseen by a doctor. Some of the guidelines for coverage also come down to the type of plan you choose, which you'll learn more about in this guide.

There's more important information in your health plan documents called Evidence of Coverage and Summary Plan Description. These documents have more details about your coverage. You can find them in your benefit administration portal, or by contacting HR. They're the final place you'll need to look if you have questions about your coverage because they're the binding agreement between you and the plan.

If you notice differences between benefits in this guide and the Evidence of Coverage or Summary Plan Description, you should go by what's written in those documents, not this guide.

When you ask your health plan to cover a supply or service, it's called a "claim." These documents have the information you need to get your claim reviewed or to dispute it if you think there's been an error.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 46 for more details.

Check out your benefits

Dig into options, programs, and resources

Keep an eye out for benefit examples

Quick note: these examples are meant to help you understand the different health plans we offer. If you have specific questions, it's a good idea to reach out to Human Resources.

Eligibility & Enrollment

Eligibility & Enrollment

Quick answers to your questions

Who can sign up?

All employees who regularly work at least 20 hours per week for the University are eligible to enroll in our benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) (hereinafter referred to as "registered domestic partner") and/or eligible children. An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee's state registered domestic partner that does not meet the definition of the employee's tax dependent under IRC Section 152.

It may be possible for a registered domestic partner and/or their child(ren) to qualify as your tax dependents for state tax purposes even when they do not qualify as your federal tax dependent(s).

When does my coverage start?

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

Once you enroll in a benefits plan, you can't make any changes until the end of the plan year, which is from January 1, 2025 – December 31, 2025.

If you miss the deadline to sign up, you can't enroll later unless you experience what's called a Qualifying Life Event. It's always a good idea to check with your plan administrator and your section 125 plan document to see if you're allowed to make a mid-year change based on your situation.

How do I sign up?

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

Can I make changes after I sign up?

After you've signed up, you can only make changes to your benefits if you have what's called a qualifying life event (QLE). A QLE is something that happens to you or someone in your family. The list of QLEs is defined by the federal government. Some examples are:

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

You might be able to add or drop coverage if one or more of these things happen to your family after you sign up. Most Qualified Life Event changes, such as getting married or having a baby, are time-sensitive and must be addressed **within 30 days**. Alternatively, if you lost eligibility or enrolled in Medicaid, Medicare, or state health insurance programs, you have to submit the request for change within 60 days. It's always a good idea to reach out to your plan administrator to find out if you can make changes.

Do I have to sign up?

You can "waive" medical coverage if you're covered through another plan, such as a plan offered through your spouse's job. To waive coverage, you must upload a completed Health Insurance Waiver Form with proof of coverage in Workday. If you elect to waive your medical coverage, the University will contribute $75 per pay period. It is important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be during Open Enrollment for plan year 2026, unless you have a Qualified Life Event.

If you don't sign up for any health insurance coverage at all, you might have to pay a penalty. Although the federal penalty requiring individuals to maintain health coverage was reduced to $0, some states have their own mandates.

To avoid paying these penalties in certain states, you can sign up for health insurance through our benefits program or purchase coverage from somewhere else, such as from a State or Federal Health Insurance Exchange.

Curious about Healthcare Reform and the Individual Mandate? Reach out to Human Resources or visit www.healthcare.gov. You can also visit www.coveredca.com for details on the Covered California State Health Insurance Exchange.

Getting Support

Health Advocate

Have you ever been stumped by a particularly tough puzzle? Sometimes you can't find that missing piece (though we recommend checking your couch cushions *one* more time). Your Health Advocate can help you solve your health care puzzle. Here are some examples of ways they can help:

Administrative Support

- Explain your coverage and coordinate benefits
- Research and resolve insurance claims and medical billing issues
- Find and schedule appointments with highly rated doctors in your network
- Help you get required pre-authorizations for medical services, durable medical equipment, and prescription drugs
- Research ways to save money on medications
- Help you transfer medical records between doctors

Clinical Decision Support

- Answer questions about medical diagnoses and review treatment options
- Research and identify the latest, most advanced approaches to care
- Help you find initial consults and second opinions
- Explain how much specific services will cost so you can make the best choices
- Help you prepare for doctor visits and review results

Call your Health Advocate toll-free at 866.799.2655. They're available Monday through Friday, 5 am to 4 pm PT.

Medical Plans

Medical Plans

Breaking down plan types (and understanding acronyms)

HMO

On a Health Maintenance Organization plan or HMO, your first important step is to choose a Primary Care Physician (PCP). Your PCP will provide you with care or refer you to other services. Any other medical services you need throughout the year must come from a certain group of providers—the ones in the plan's network. If you go to a provider or facility outside the network, the health plan will not pay for those services unless it's an emergency.

Advantages

Out-of-pocket costs are lower

Your care is coordinated by your PCP

Ideal if...

...you are comfortable with a PCP directing your care.

Out-of-pocket costs

Your health plan can charge different fees such as a flat fee called a "copay", a fee that's a percentage of the total cost of the service, called "coinsurance", and an amount that must be paid before your plan kicks in, called a "deductible." Sometimes, these types of fees are lower in an HMO than they are in other types of plans.

Using an HMO plan: an example

Ben needed an annual exam but was also worried about an area on his skin. Ben called the primary care physician (PCP) that he elected and made an appointment. Ben told the PCP about his skin concerns, and the PCP referred Ben to a dermatologist in the plan network.

That worked great for Ben. He was too overwhelmed to find the dermatologist himself, and he likes coordinating his care with the PCP. Ben paid his visit cost, which will count toward the out-of-pocket cost.

Using an HMO (In-network)

Primary Care Physician › **Referral** › **Specialist**

HDHP

On a High-Deductible Health Plan (HDHP), you have to pay more out-of-pocket before your health plan starts covering services. The amount you have to pay before the plan kicks in is called the "deductible." To help cover these expenses, you can access a special savings account called a "Health Savings Account (HSA)." You can contribute pre-tax funds to this account and use it to pay for different health-related expenses called "qualified medical expenses."

Advantages

An HDHP is a Preferred Provider Organization (PPO) medical plan that allows you to see any healthcare provider, including specialists, without needing a referral. Keep in mind that using in-network providers is more cost-effective.

Your HSA can help you save on taxes. Funds in an HSA can be used for a wide range of qualified medical expenses.

Out-of-pocket costs

If you choose an HDHP, you'll pay most of your out-of-pocket expenses upfront until you reach your deductible.

Ideal if...

...you don't usually need much health care throughout the year and have enough money set aside to cover expenses until you reach your deductible.

Note:

You can only use your HSA funds to pay for qualified medical expenses, such as copay fees and purchases of over-the-counter medications. It's a good idea to keep your receipts in case your taxes are audited.

Using an HDHP plan: an example

Taylor rarely goes to the doctor, but when she experienced a fever, chills, and chest congestion, she decided to visit urgent care. Taylor found a nearby in-network urgent care clinic for treatment. Because Taylor hadn't yet met the plan's annual deductible, she used funds from her Health Savings Account (HSA) to pay for the visit.

Taylor had savings set aside, so she was prepared for this visit. Taylor paid a coinsurance, which counts toward the plan's annual deductible.

Using a HDHP (In-network or Out-of-network)

HSA Funds › **Primary Care Physician** or **Specialist**

EPO (Available to Remote Employees Based Outside of CA)

An Exclusive Provider Organization (EPO) Plan contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Using providers that belong in the plan's network will provide predictable low out of pocket costs for services. If you go to a provider or facility outside the network, the health plan will not pay for those services unless it's an emergency.

Advantages

Out-of-pocket costs are lower

No referrals required for specialists

Ideal if...

... you primarily use in-network providers and prefer lower premiums.

Out-of-pocket costs

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

Note:

An EPO plan will cover out-of-network care only in emergencies.

Using an EPO plan: an example

Andy has a complex endocrine condition and knew it was important to choose a health plan that minimized out-of-pocket expenses, while offering a broad choice of in-network only providers. Andy visited the insurance company website to find an in-network specialist within the plan's provider network.

After a recent visit with an endocrinologist, Andy was responsible for a copay, which counted toward the out-of-pocket maximum. This plan works well for Andy because Andy's fees for each in-network provider visit are lower, and he did not need a referral to visit his endocrinologist.

.

Using an EPO (In-network)

Primary Care Physician

or

Specialist

To find a provider in your plan's network:

Kaiser

- Go to www.kp.org and select "Doctors & Locations".
- Search by location, physician name, medical specialty, or advanced search.
- Use the "Health Plan" drop down menu and select plan name.
- Physician profiles and locations available will appear.

Aetna

- Go to www.aetna.com and select "Find a doctor"
- Under Don't Have a Member Account?, select "Plan from an employer"
- Under Continue as Guest, enter in your zip code and preferred radius and select Search
- From here select the Plan you wish to search. The plans available through SCU are:
    - For the Aetna AWH HMO plan:
        - Under Aetna Whole Health Plans Select the following:
            - (CA) Aetna Whole Health℠ - Northern California HMO
    - For the Aetna HMO plan:
        - Under Aetna Standard Plans select the following:
            - HMO
    - For the Aetna PPO with HSA (HDHP) plan:
        - Under Aetna Open Access Plans select the following:
            - Managed Choice® POS (Open Access)
    - For the Aetna EPO plan (out-of-state employees only):
        - Under Aetna Open Access Plans Select the following:
            - OA Elect Choice EPO (Open Access)

- Once you have selected the plan above, you will be able to search for providers, urgent care centers, hospitals, mental health providers, etc.

Saving money on your medications

Your benefits cover a lot of prescription medications, but how much you pay for them, and how much your health plan covers, is determined by a system of "tiers." These tiers are more like a layer cake than a rating system: The quality is the same no matter where you are, but the higher you go on these tiers, the more expensive and/or hard to access the medication may be.

Here are some examples of the types of medications in each tier:

Tier 1 - Generic Formulary:

These medications have the same active ingredients as brand-name medications, but they cost less.

Tier 2 - Brand name:

These medications are only made by one manufacturer. They're proven to be the most effective medications in their class.

Tier 3 - Non-Preferred:

Medications that aren't on your health plan's list of preferred medications, which is called their "formulary." Usually, this happens when there is a safe and effective alternative that is less expensive—often a generic. If your doctor prescribes a non-formulary medication, it's a good idea to speak with them or your pharmacist about generic alternatives.

Tier 4 - Specialty:

These medications treat chronic or complex conditions. They might require special storage or careful monitoring.

Why pay more for your medications?

Use the mail

You can save time and money by getting your medications shipped directly to you through a mail-order service. You can have a larger quantity, usually a 90-day supply, regularly shipped to your door. Go to www.kp.org or www.aetna.com to sign-up for delivery service.

Shop around

Some pharmacies offer less expensive medications. Try calling pharmacies inside warehouse clubs or discount stores to see if they offer a lower price. Shopping around could pay off.

Try over-the-counter

For colds, headaches, and other common conditions, over-the-counter medications can sometimes work just as well as prescription ones—and cost a lot less, too.

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

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider. The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions

Plan Highlights	Aetna AWH NorCal HMO	Aetna HMO
Plan Description	You choose a Primary Care Physician to coordinate all of your healthcare. Services obtained from non-authorized providers will not be covered by Aetna.	You choose a Primary Care Physician to coordinate all of your healthcare. Services obtained from non-authorized providers will not be covered by Aetna.
Plan Network Detail	(CA) Aetna Whole Health - Northern California HMO	Aetna Standard HMO
Annual Calendar Year Deductible		
Individual/Family	None	None
Maximum Calendar Year Out-of-pocket (1)		
Individual	$2,000	$2,000
Family	$4,000	$4,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Office Visit	$20 Copay	$20 Copay
Specialist Care Office Visit	$20 Copay	$20 Copay
Routine Physical Exam / Preventive Care	No Copay	No Copay
Diagnostic X-ray / Lab	No Copay	No Copay
Chiropractic Services - 20 visits/year	$15 Copay	$15 Copay
Acupuncture Services – 20 visits/year	$20 Copay	$20 Copay
Hearing Aid Benefit	20% coinsurance, $4,000 benefit maximum every 24 months	20% coinsurance, $4,000 benefit maximum every 24 months
Hospital Services		
Room & Board	$250 Copay per Admission	$250 Copay per Admission
Maternity Services	$250 Copay per Admission	$250 Copay per Admission
Urgent Care	$20 Copay	$20 Copay
Emergency Room Visit (waived if admitted)	$100 Copay	$100 Copay
Mental Health & Substance Abuse		
Inpatient	$250 Copay per Admission	$250 Copay per Admission
Outpatient	$20 copay	$20 copay
Prescription Drugs		
Contraceptive Drugs	No Charge	No Charge
Tier 1 (30-day supply)	$5 Copay	$5 Copay
Tier 2 (30-day supply)	$20 Copay	$20 Copay
Tier 3 (30-day supply)	$40 Copay	$40 Copay
Tier 4 (30-day supply)	20% to $200 Copay	20% to $200 Copay
Mail Order (90-day supply)	Tiers 1, 2 & 3: 2x Retail Copay	Tiers 1, 2 & 3: 2x Retail Copay

(1)Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider. The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights	Aetna EPO
Plan Description	This plan is for Non-California Employees Only
Plan Network Detail	In-network OA Elect Choice EPO
Annual Calendar Year Deductible	
Individual	$0
Family	$0
Maximum Calendar Year Out-of-pocket (1)	
Individual	$2,000
Family	$4,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Office Visit	$20 Copay
Specialist Care Office Visit	$20 Copay
Routine Physical Exam / Preventive Care	No Charge
Diagnostic X-ray / Lab	No Charge
Chiropractic Services - 20 visits/year	$15 Copay
Acupuncture Services – 20 visits/year	$20 Copay
Hearing Aid Benefit	20% coinsurance, $4,000 benefit maximum every 24 months
Hospital Services	
Room & Board	$250 Copay
Maternity Services	$250 Copay per Admission
Urgent Care	$25 Copay
Emergency Room Visit (waived if admitted)	$100 Copay
Mental Health & Substance Abuse	
Inpatient	$250 Copay per Admission
Outpatient	$20 copay
Prescription Drugs	
Contraceptive Drugs	No Charge
Tier 1 (30-day supply)	$5 Copay
Tier 2 (30-day supply)	$20 Copay
Tier 3 (30-day supply)	$40 Copay
Tier 4 (30-day supply)	20% to $200 Copay
Mail Order (90-day supply)	Tiers 1, 2 & 3: 2x Retail Copay

(1)Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider. The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights	Aetna PPO with HSA (HDHP)	
Plan Description	Access to in-network and out-of-network providers. The plan deductible must be met before the coinsurance and copays outlined below will apply. Ability to open a Health Savings Account (HSA) and contribute pre-tax funds to the account.	
Plan Network Detail	OA Managed Choice POS HDHP (OAMC)	
	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual	$2,000	$4,000
Individual within Family	$3,300	$4,000
Family	$4,000	$8,000
Maximum Calendar Year Out-of-pocket (3)		
Individual	$4,000	$8,000
Individual within Family	$4,000	$8,000
Family	$8,000	$16,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Office Visit	Covered at 90%	Covered at 70%
Specialist Care Office Visit	Covered at 90%	Covered at 70%
Physician Home Visit	Covered at 90%	Covered at 70%
Routine Physical Exam / Preventive Care	Covered at 100%	Covered at 70%
Diagnostic X-ray / Lab	Covered at 90%	Covered at 70%
Chiropractic Services - 20 visits/year	Covered at 90%	Covered at 70%
Acupuncture Services - 20 visits/year	Covered at 90%	Covered at 70%
Hearing Aid Benefit Limited to 1 pair of hearing aids every 24 months	Covered at 90%	Covered at 30%
Hospital Services		
Room & Board	Covered at 90%	Covered at 70%
Maternity Services	Covered at 90%	Covered at 70%
Urgent Care	Covered at 90%	Covered at 70%
Emergency Room (waived if admitted)	Covered at 90%	Covered at 90%
Mental Health & Substance Abuse		
Inpatient	Covered at 90%	Covered at 70%
Outpatient	Covered at 90%	Covered at 70%
Prescription Drugs		
Tier 1 (30-day supply)	$5 Copay	N/A
Tier 2 (30-day supply)	$20 Copay	N/A
Tier 3 (30-day supply)	$40 Copay	N/A
Tier 4 (30-day supply)	30% up to $250 Copay	N/A
Mail Order (90-day supply)	Tiers 1, 2 & 3: 2x Retail Copay	Not Covered

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider. The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Wellness Programs

Wellness Programs

Benefits for your body and mind

What is wellness—and why should I care?

The steps to choosing your benefits may be getting clearer, but when it comes to your overall well-being, it's all about the journey, not the destination. Be sure to bring along the right tools and an enthusiastic support system! Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. Your wellness benefits support this approach to total well-being for your mind and body. Plus, they're free.

Wellness Program

Santa Clara University's Mission to Wellness

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

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

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

Dental Plan

Dental Plan PPO

Taking care of your smile

With the Dental PPO plan, you can pick any licensed dentist. Just keep in mind that your dental plan has settled on lower rates with a smaller group of providers—those in their network. If you choose a dentist outside that network for yourself or your dependents, you might have to pay more.

To find out if your dentist is in your provider network, you can search www.guardianlife.com/dental-insurance, select find a provider and then select DentalGuard Preferred or call Guardian at (800) 541-7846.

"How much will specific services cost?"

Plan Highlights

Guardian Dental PPO

	In-network	Out-of-network
Calendar Year Deductible		
Individual	$25	$25
Family	$75	$75
Annual Maximum	$3,500	$3,500
Preventive	100%	100%
Basic Services	100%	80%
Major Services	60%	50%
Orthodontia Services		
Adults	50%	50%
Children to age 26	50%	50%
Lifetime Maximum	$3,000	$3,000

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

Maximum Rollover

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

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

Vision Plan

Vision Plan PPO

Bringing your benefits into focus

Anthem Blue View offers vision coverage as a Preferred Provider Organization (PPO) plan. With the vision plan, you can pick where to receive services. Just keep in mind that your vision plan has settled on lower rates with a smaller group of vision providers—those in their network. If you choose a vision provider outside that network for yourself or your dependents, you will have to pay for all the expenses yourself at the time of service. Then, you'll submit a claim, and Anthem Blue View will reimburse you up to a certain "allowed" amount.

To find out if a vision provider is in your network, you can search on www.anthem.com/ca.

Plan Highlights

Anthem Blue View Vision PPO

	In-network	Out-of-network
Exam – Every 12 months	$20 copay	$45 copay
Lenses – Every 12 months		
Single	Covered at 100%	Covered up to $45
Bifocal	Covered at 100%	Covered up to $65
Trifocal	Covered at 100%	Covered up to $85
Progressive	$0 after eyeglass lens copay	Not Covered
Frames – Every 12 months	Covered at 100% up to $150	Covered up to $47
Additional Pairs of Glasses	40% off retail price for complete pair	
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	Covered at 100%	Covered up to $210
Cosmetic	Covered up to $120	Covered up to $105

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

Spending Accounts

Spending Accounts

Make your money work for you

Health Savings Account (HSA)

When you sign up for a Aetna High-Deductible Health Plan (HDHP), you can open a type of bank account called a Health Savings Account (HSA). This account allows you to save money for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses. The money you put in your HSA is not federally taxed.

What to know about your health savings account

It's all yours—you own your HSA and your funds can accumulate year after year

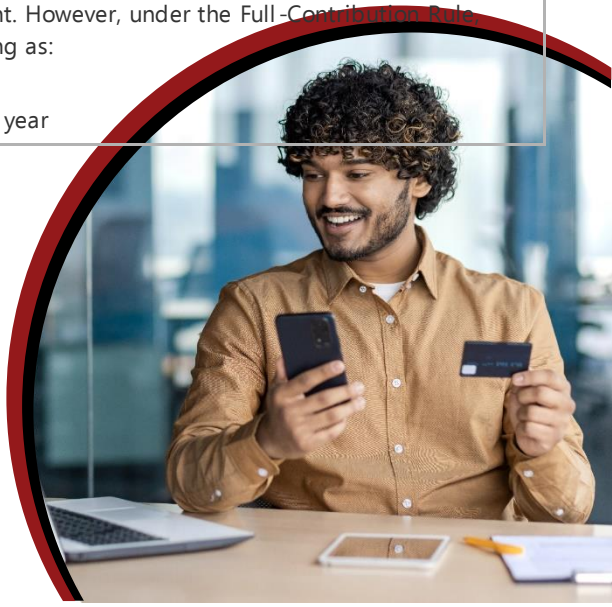
You choose how much to contribute up to an annual maximum

You have to be enrolled in a High-Deductible Health Plan in order to contribute

HSA funds are not taxed as long as you use the funds for qualified expenses

HSA Facts

What are the benefits?	• HSA funds aren't taxed and can continue to grow tax-free, subject to state law. Talk to your tax advisor to find out what applies in your state. • An HSA reduces your taxable income, so it may allow you to pay for qualified health care expenses tax-free. Just remember that tax regulations vary by state. • HSAs are paired with HDHPs. • **Santa Clara University contributes $50/month to your HSA for employees enrolled in the Aetna HDHP.** Employer HSA contributions are contingent upon an employee informing an employer that they have opened a HSA account. Employer HSA contributions are deposited into an employee's HSA account on a pro-rata basis, contingent upon how many months an employee is HSA eligible and enrolled in Santa Clara University's HDHP during the year and whether they have a valid account open to receive employer HSA contributions. Employees may forfeit employer contributions if they fail to meet these conditions.
How do I become eligible to contribute to an HSA?	• You're eligible if you enrolled in an HDHP. There are a few other rules to keep in mind, as well. You can't be enrolled in non-qualified health insurance outside of Santa Clara University's plan or in Medicare, can't be claimed as a dependent on someone else's tax return (excluding a spouse), can't get any hospital care or medical services from the Veterans Administration in the previous three months (unless these services were related to a service-connected disability) and can't be enrolled in a general Healthcare Flexible Spending Account (Health FSA) or a general Health Reimbursement Arrangement (HRA).
How do I get started?	• The most convenient way to pay for qualified expenses is to utilize the debit card. You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account. It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS. If you're ready to activate your HSA account, you can do so by: - Activating your account at https://www.healthequity.com/ - Scroll down to find step-by-step video tutorials on various topics. • Once the HSA is activated, you can manage and access your account at any time. Consult your tax advisor for taxation information or advice.
A few rules to keep in mind…	• **For 2025, the maximum that you and your employer together can contribute to your HSA account is $4,300 if you are enrolled in the HDHP for employee-only coverage. If you're enrolled in a plan with dependents, the maximum is $8,550.** There is a $1,000 catch up for those employees age 55 and older. This maximum is set by the IRS, and it's important that you don't go over it. • If you go over the IRS limit, the amount you go over will be taxed at standard income tax rates, plus a 6% excise tax. • If you use your HSA funds to pay for non-qualified expenses, you'll pay taxes on the funds as well as a 20% penalty (unless you are over age 65). Once you reach age 65, you can use your hoarded cash however you want. You can find more info about qualified health care expenses at https://www.irs.gov/pub/irs-pdf/p502.pdf. • Typically, the amount you can contribute to your HSA in a calendar year is pro-rated based on when you became eligible. So, if you become HSA-eligible on September 1st, you can only contribute ⅓ of the maximum annual limit during your first year of enrollment. However, under the Full-Contribution Rule, you can still contribute up to the annual maximum as long as: • You're HSA-eligible on Dec. 1 of the plan year, and • You're still HSA-eligible through Dec. 31 of the following year



Flexible Spending Account (FSA)

With this type of account, you and your spouse, plus any eligible dependents, can use pre-tax dollars to cover health care/dependent care/transit/parking. There are different types of FSAs, but they all help reduce your taxable income. Here are the different types of FSAs.

	**Healthcare FSA**	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • For a list of qualified expenses: https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/ • Minimum contribution for 2025 is $300. • Maximum contribution for 2025 is $3,300.
	**Limited Purpose FSA**	• Employees may want to consider a limited purpose FSA if they are HSA eligible and plan to contribute to an HSA during the plan year. • This FSA may be used to reimburse qualified preventive care, dental, and vision expenses. • For a list of qualified expenses: https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/ • Minimum contribution for 2025 is $300. • Maximum contribution for 2025 is $3,300.
	**Dependent Care FSA**	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • For a list of qualified expenses: https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/ • Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time. • Minimum contribution for 2025 is $600. • Maximum contribution for 2025 is $5,000.
	**Commuter Spending Account**	• Can be used to cover qualified transit passes, vanpooling, payments for transportation in a commuter highway vehicle, and qualified parking costs. • Parking maximum contribution for 2025 is $325 per month. • Transit maximum contribution for 2025 is $325 per month. • Cash reimbursement is not allowed. You must use the FSA Debit card for all parking and transit purchases.

What are the benefits?

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

How do I use it?

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

A few rules you need to know:

- You may carryover up to $660 from your 2025 health FSA to the 2026 plan year.
- Although the plan year runs from January 2025 through December 2025, the plan allows an annual run-out period through March 31st. 2026 allowing you to seek reimbursement for any expenses incurred during the plan year (from January 1st, 2025 to December 31st, 2025.)

How to use your Flexible Spending Account

Determine your estimated FSA healthcare expenses for the plan year

Set up annua (pre-tax) deductions from your paycheck

Use FSA debit card or submit a claim to your administrator with receipts as proof of your incurred eligible expenses

Use it or lose it – any funds that remain in the FSA at the end of the plan year are forfeited.

SCU plan allows up to $660 of Healthcare FSA funds to roll over to the next year.

Life & Disability

Life & Disability

Life Insurance and AD&D

There's no easy way to talk about death, but your family might need help if something happens to you. A life and accidental death and dismemberment (AD&D) policy can provide that help. You are automatically signed up for this benefit and your family will be paid a lump sum of money when you die. If your death was caused by an accident, or if you lose a limb, you or the people you choose, called "beneficiaries," may get additional coverage.

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

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

Quick note on IRS Regulations: You can receive employer-paid life insurance coverage up to $50,000 on a tax-free basis and do not have to report the payment as income. However, coverage of more than $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

Additional Benefits include Will Preparation, Claimant Support Services, Travel Assistance & Identity Theft:

- **Online Will Preparation:** Online Will Preparation is provided by ComPsych to active employees enrolled in Sun Life's insurance. Through an easy-to-use secure website, you and your spouse can create and download a will in about 20 minutes. To protect your assets and loved ones, you can go online to create and download a will at www.estateguidance.com enter code: SLF4VAS.
- **Claimant Support Services:** You have access to no-cost, objective financial planning, legal information, and emotional support. If you need to talk to a counselor or need legal or financial information because of a life or Disability insurance claim with Sun Life, you can call ComPsych for no cost at 888.475.3827.
- **Travel Assistance:** Reliance Matrix offers 24/7 emergency travel assistance to you and your dependents. Whether you need help with an illness or injury, lost passport, missing luggage or even a prescription refill, you and your covered dependents have access to a personal travel emergency companion anytime you're more than 100 miles away from home. To seek services call (US) 800.456.3893 or (Worldwide) 603.328.1966.
- **Identity Theft:** When Identify Theft occurs oftentimes it's difficult to think about everything you will need to do. With a trusted partner by your side, InfoArmor's unique combination of proprietary technology and remediation expertise provides peace of mind every step of the way so you can live confidently. To access, call 855.246.7347.

Voluntary Life and AD&D

You have the option to add more life insurance coverage for yourself and your dependents through Sun Life. Premiums for approved voluntary coverage will be deducted from your paycheck. Here are the details about the voluntary options:

	**For employees:**	Increments of $10,000 up to a $500,000 maximum with a guarantee issue benefit of $300,000 if you enroll in the plan within 30 days of your initial eligibility.
	**For your spouse:**	Increments of $5,000 up to a $100,000 maximum or 50% of the Employee's Basic and Voluntary Life amount combined, whichever is less. The guarantee issue benefit is $50,000 if you enroll in the plan within 30 days of your initial eligibility.
	**For your child(ren):**	From birth up to 6 months of age, flat $500; Over 6 months old up to age 26, increments of $2,000 up to a maximum $10,000.

If you choose to get additional coverage, the insurance company may want to make sure you're in good health. The insurance amounts here, unless noted as guaranteed issue, are subject to review and won't be effective until the insurance company approves.

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

Don't forget to update your beneficiaries!

- The people or entities who you want to receive benefits from your policy are called beneficiaries. It's very important that they are up to date.
- You may change your beneficiaries at any time.
- You may designate one person as your beneficiary or choose multiple beneficiaries, who will each get a percentage of the payout amount.
- To select or change your beneficiary, log in to Workday or contact Human Resources.

Disability Insurance

When you're too sick or injured to work, you need time to focus on healing—not worrying about your income. Enrolling in disability insurance offers you and your family peace of mind by helping to replace some of your income if you have a non-work related illness or injury. Your eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short Term Disability (STD)	• Administered by Matrix, STD coverage provides a benefit equal to 70% of your earnings, up to $1,700 per week for a period up to 52 weeks. • The plan begins paying these benefits at the time of disability/after you have been absent from work for 7 consecutive days. • For additional information please visit: https://scu.edu/hr/quick-links/staff-policy-manual/policy-603---short-term-disability-benefits/
Long Term Disability Coverage (LTD)	• If your disability extends beyond 360 days, the LTD coverage through Reliance Standard can replace 66.66% of your earnings, up to maximum of $10,000 per month. • Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability. • For additional information please visit: https://scu.edu/hr/quick-links/staff-policy-manual/policy-603---short-term-disability-benefits/
State Disability Insurance	• For more information regarding statutory disability programs, contact Human Resources

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

Retirement

Retirement

Planning for the future

Your 401(k) Plan

No matter how wonderful your job is, it's good to plan ahead for retirement. A 401(k) plan helps you plan for your future by squirreling away a portion of each paycheck. These funds are withdrawn each pay period and invested so they can grow (subject to federal law and plan guidelines). You can withdraw the funds when you retire.

See Human Resources to confirm whether you're eligible and when you can enroll.

University Retirement Plan: 401(a) Retirement Plan

The Santa Clara University Defined Contribution Plan

1. The equivalent of 10% of your base salary is submitted on your behalf to the retirement fund sponsor of your choice each pay period. This benefit is fully funded by Santa Clara University.
2. Choose either Fidelity Investments or TIAA as your fund sponsor for this plan. Fidelity and TIAA Investments have over 50 investment options. Please see fund performance and prospectus of the appropriate plan sponsor for details.
3. You are 100% vested once you have worked in a benefits eligible position for a minimum of 1000 hours in each of 2 consecutive calendar years.

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

- This benefit is funded by voluntary employee contributions expressed in a flat amount of a percentage of salary. You can contribute any amount you wish up to the IRS calendar year limits.
- Choose either Fidelity Investments or TIAA as your fund sponsor for this plan. Fidelity and TIAA Investments have over 50 investment options. Please see fund performance and prospectus of the appropriate plan sponsor for details.
- You are 100% Vested as of the date of your first contribution.
- 2025 maximum contribution is $23,000. If you are age 50 or over, you can contribute an additional $7,500 of catch-up contributions.

Retirement Plan Portal

The University selected Fidelity, one of our current retirement plan vendors, to manage the SCU Retirement Plans Portal.

Whether you have your 401(a) or 403(b) account with Fidelity or TIAA, SCU Retirement Plans Portal will provide you with the ability to:

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

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

Note: Per IRS regulations, IRC 415(c), the combined (employer 401(a) contributions and employee 403(b) contributions) cannot exceed the employee's annual base earnings. *As of the time this guide was created, the IRS has not announced the 2025 401(k) maximum.

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

Employee Assistance Program (EAP)

Employee Assistance Program

Free resources for tough moments

Your Employee Assistance Program (EAP) is a set of services that can support you through personal and professional challenges with resources, information, and counseling. Everything is confidential—what you talk about won't be shared with your employer—and free.

Program Component	Coverage Details
Number of sessions	10 face-to-face sessions per 12 consecutive month period per member per incident
How to access	Phone or face-to-face sessions
Topics may include	**Mental Health Support:** • Marital, relationship or family problems • Bereavement or grief counseling • Substance use disorder and recovery **Community Support:** • Child and eldercare • Legal services and identity theft • Financial support
Who can utilize	You, your dependents, and even other members of your household.

Get in touch:

By phone: 800.344.4222

Online:
www.login.concernhealth.com/scu

Website password: scueap

Perks & More

Perks & More

Finally, the fun stuff

Your benefits package isn't all insurance. It still knows how to have fun. In that spirit, your employer gives you these perks.

Holidays

These are our company's paid holidays.

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

This Section of Benefits Applies to Staff Only

Paid Time Off (PTO)

The **Paid Time Off (PTO)** program allows employees to use a maximum of 32 hours of accrued sick leave during any 12 month period to attend to personal matters. Please see https://www.scu.edu/hr/employee-resources/policies-and-guidelines/staff-policy-manual/policy-617---personal-leave/ for details.

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

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

Paid Family Leave

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

The plan pays 70% of your base monthly earnings to a maximum weekly benefit of $1,700 and a minimum of $50 for up to 8 weeks.

For additional information please visit: https://www.scu.edu/hr/benefits/time-off-benefits/paid-family-leaves/ or call Matrix Absence Management at (877) 202-0055 or visit https://www.matrixabsence.com/.

Education Benefits

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

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

Tuition Remission

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

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

Tuition Reimbursement

The Tuition Reimbursement program provides eligible employees with Tuition Reimbursement for themselves or their dependents of up to $3,000.00 per year, with a lifetime benefit limit of $12,000.00 per employee, for tuition and educational fees.

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

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

FACHEX

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

Tuition Exchange

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

Kids on Campus

About KOC

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

General Enrollment Information

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

Space in KOC is reserved on a descending order and is only available to children of benefits-eligible faculty and staff with first priority given to:

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

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

Even More Coverage Options

EE Paid Pre-Tax Cancer Protection Plan

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

Golden State Scholarshare Plan (CA 529 Plan)

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

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

Discounts, Memberships & More

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

Human Resources also coordinates financial consultations through Heffernan. To schedule an appointment, please contact the HR Service Desk at extension 4392. We encourage you to visit our website at: https://www.scu.edu/hr/benefits/perks--rewards/ to explore all the benefits of working at Santa Clara University!

Employee Emergency Loan Program (EELP)

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

Eligibility: All regular benefits eligible University employees who have successfully completed one year of service and are in good standing (have not been demoted, suspended, or received a written warning or improvement plan from their supervisor in the past three years) are eligible to apply for EELP loans. The EELP program is managed through the Department of Human Resources. To apply for an EELP loan employees must complete an EELP application form and submit it to the Department of Human Resources. The fact that an employee has applied for, been denied, or received an emergency employee loan is kept strictly confidential. Contact the Director of Employee Development & Wellness for additional information or to apply at 408-544-6990 or smmata@scu.edu

Costs & Directory

Costs Breakdown

Let's sum it all up!

The rates below are effective January 1st, 2025 – December 31st, 2025.

Coverage Level	Employee Contribution	SCU Contribution	Total Cost
	Per Pay Period	Per Pay Period	Per Month
Aetna AWH NorCal HMO			
Employee Only	$9.44	$487.91	$994.69
Employee + One Dependent	$99.47	$944.95	$2,088.84
Employee + Two or More Dependents	$188.22	$1,303.81	$2,984.06
Aetna HMO			
Employee Only	$63.88	$687.72	$1,503.20
Employee + One Dependent	$271.27	$1,307.08	$3,156.69
Employee + Two or More Dependents	$411.82	$1,842.97	$4,509.57
Aetna PPO with HSA (HDHP)			
Employee Only	$96.45	$843.89	$1,880.67
Employee + One Dependent	$328.22	$1,646.49	$3,949.41
Employee + Two or More Dependents	$520.80	$2,300.21	$5,642.01
Aetna EPO – Non-CA Only			
Employee Only	$65.28	$702.85	$1,536.25
Employee + One Dependent	$277.24	$1,335.82	$3,226.11
Employee + Two or More Dependents	$420.88	$1,883.49	$4,608.74
Kaiser Permanente HMO			
Employee Only	$37.87	$504.15	$1,084.04
Employee + One Dependent	$211.12	$872.92	$2,168.07
Employee + Two or More Dependents	$318.44	$1,215.48	$3,067.83
Guardian Dental PPO			
Employee Only	$0.00	$41.25	$82.50
Employee + One Dependent	$9.85	$56.60	$132.90
Employee + Two or More Dependents	$22.50	$76.37	$197.74
Anthem Blue View Vision PPO			
Employee Only	$2.31	$2.52	$9.65
Employee + One Dependent	$3.20	$3.84	$14.08
Employee + Two or More Dependents	$5.39	$7.10	$24.97

Directory & Resources

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

Information Regarding	Group / Policy #	Contact Information	
Medical Coverage			
Aetna			
• AWH HMO		800.445.5299	
• HMO	237642	800.445.5299	
• OAMC POS (HDHP)		877.204.9186	
• EPO		877.204.9186	www.aetna.com
Kaiser			
• HMO	979		
		800.464.4000	www.kp.org
Dental Coverage			
Guardian			
• PPO	00056564	800.541.7846	www.guardiananytime.com
Vision Coverage			
Anthem Blue View Vision			
• PPO	175028	866.723.0515	www.anthem.com/ca
Life, AD&D and Disability			
Sun Life			
• Life/AD&D	942423	800.247.6875	www.sunlife.com/account
• Voluntary Life			
Matrix Absence Management			
• STD		877.202.0055	www.matrixabsence.com
• Paid Family Leave	170701		
Reliance Standard			
• LTD	170701	800.351.7500	www.reliancestandard.com
Flexible Spending Accounts			
WEX		866.451.3399	www.wexinc.com
Health Savings Account			
HealthEquity		877.857.6810	www.healthequity.com
401(k) Retirement Plan Adviser			
TIAA		800.842.2252	www.tiaa.org
Fidelity		800.343.0860	www.fidelity.com/atwork
Retirement Planning Portal			www.netbenefits.com/scu
Employee Assistance Plan			
Concern	Access Code: **scueap**	800.344.4222	www.concern-eap.com
Back-up Care for child(ren), adults and pets			
Bright Horizons	Employee ID		https://clients.brighthorizons.com/scu
CA 529 Plan			
Golden State ScholarShare		800.544.5248	www.scholarshare.com
Health Advocacy Services			
Health Advocate		800.695.8622	www.healthadvocate.com/members
Benefits Broker			
Marsh & McLennan Insurance Agency LLC 1255 Treat Blvd, Suite 950 Walnut Creek, CA 94597		925.482.9300	www.MarshMMA.com

Thanks for Reading

This guide contains just a few (or a few more than a few) words about your benefits, but it represents a network of resources and support. Now it's time to get back to living—knowing that this guide is here when and if you ever need it. If questions slow you down, keep in mind that Human Resources would be happy to help.

Here's to a happy, healthy year ahead!

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

For the 2025 Plan Year

Dear Valued Employee,

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

Enclosures:

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

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

Medicare Part D
Creditable Coverage Notice

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

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

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

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. **Santa Clara University has determined that the prescription drug coverage offered by Aetna and Kaiser is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Santa Clara University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Santa Clara University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Name of Entity/Sender: Santa Clara University
Contact-Position/Office: Human Resources
Address: 500 El Camino Real Santa Clara, CA 95053

HIPAA Special Enrollment Rights Notice

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

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

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

HIPAA Notice of Privacy Practices

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

Santa Clara University sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage

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

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

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

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

Contact Information

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

Santa Clara University, Inc.
Attention: HIPAA Privacy Officer
500 El Camino Real
Santa Clara, CA
95053

Effective Date

This Notice as revised is effective January 1st, 2025.

Our Responsibilities

We are required by law to:

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

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material

change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

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

For Treatment

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

For Payment

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

For Health Care Operations

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

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected

health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

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

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

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

Special Situations

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

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

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

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

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

- to prevent or control disease, injury, or disability;

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

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

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

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

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

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

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

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official

if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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

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

Required Disclosures

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

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

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

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

Other Disclosures

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

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

Spouses and Other Family Members

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

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

Your Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremiumassistance@accenture.com

TTY: Maine relay 711	
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA - Medicaid	**NEBRASKA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program| Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

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

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

Model General Notice of
COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or

- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events,

or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Notes

Notes

Prepared by: **Marsh & McLennan Insurance Agency LLC**

www.MarshMMA.com | CA Insurance Lic: 0H18131