Human Resources
Association of Universities for Research in Astronomy

Benefits Guide

For Employees in

Chile

TABLE OF CONTENTS

That is why at AURA we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance including:

- Medical, Vision, & Dental Insurance
- Global Emergency Assistance
- Employee Assistance Program
- Flexible Spending Accounts (FSA)
- Basic Term Life and Accidental Death and Dismemberment Insurance
- Voluntary Term Life and Accidental Death and Dismemberment Insurance
- Short and Long Term Disability
- 401(a) & 403(b) Retirement Savings Plans

We are pleased to provide you and your family with a comprehensive benefits package that addresses your personal health, medical and financial well-being. We encourage you to examine this booklet carefully in order to understand the benefits available to you and your family members.

*The Best Decisions...*are based on information. This booklet has been prepared to assist you in evaluating the benefit options available through AURA.

- This guide is an **overview of the benefit plans** and should not be construed as the individual Summary Plan Descriptions. It should not be relied upon to fully determine coverage. If differences exist between this Employee Benefits Summary and the Certificate of Coverage, the certificate governs.
- For each benefit elected, you will receive a Summary Plan Description and detailed coverage information from the insurance carrier or Human Resources. If you are uncertain about any provisions specified in this guide, please refer to the Certificate of Coverage that will govern.

Introduction

We believe that our benefits offer you both choice and opportunity. They remain competitive and affordable in the marketplace. Best of all—they provide you with a great benefits package value.

This Benefits Guide provides general information to get you started; however, more detailed information is available within the contracts between AURA and the insurance providers. ***These legal documents always govern and determine your exact benefits.***

Information within this Guide is subject to change throughout the plan year.

Benefits Eligibility

Who is eligible for coverage?

All regular Full-Time and Part-Time employees scheduled to work 20 or more hours per week. ***Part-time employees are NOT eligible for STD, LTD, and Tuition Reimbursement***. Employees may elect coverage for themselves, a spouse or domestic partner, and dependent child(ren) who are under the age of 26 for Medical, Dental, and Voluntary Life/AD&D. ***Domestic partners are NOT eligible for Voluntary Life/AD&D.***

When can I enroll for coverage?

- First of the month following or coincident with date of employment
- Open Enrollment
- Qualifying Event (see "What is a Qualifying Event" below)
- Upon eligibility you must submit a form in order to enroll or decline coverage within 30 days of your eligibility

What is Open Enrollment?

Open Enrollment is the time of year during which you can newly enroll for benefits, make changes to existing benefit elections, or terminate coverage. Open Enrollment is usually held each November with an effective date of January 1st. Our benefit plan year runs January 1st – December 31st.

This is the only time of the year that you can make changes without experiencing a Qualifying Event.

All enrollment changes must be submitted using the Ultipro system. ONLY enter the session if you need to make change or enroll in the Flexible Spending Accounts. If you do not need to make any benefit changes or enroll in an FSA please DO NOT log into the Ultipro system.

What is a Qualifying Event?

A Qualifying Event includes:

- Marriage, Divorce, or Legal Separation
- Birth or Adoption of a Child
- Death of a Spouse or Child
- Spouse's Open Enrollment
- Change in Spouse's Employment and/or Insurance Coverage
- Becoming eligible for Medicare
- Becoming eligible for or losing Medicaid
- Child attains limiting age

You must notify Human Resources within 30 days of the date of a Qualifying Event if you wish to add, drop, or change coverage (AHCCCS participants have 60 days). Otherwise, you will have to wait until next year's Open Enrollment period to make changes.

Paying for Benefits

How do I pay for my benefits?

You and AURA share the cost of your benefits coverage. AURA pays 100% of the premium for employee only Medical and Dental coverage. Employees share in the cost for dependent medical and dental coverage. AURA pays the full cost of Emergency Global Assistance, Employee Assistance Program, Basic Life/AD&D, STD, and LTD. Employees are responsible for the full cost of Voluntary Life/AD&D plans. Benefits premiums are deducted each pay period.

AURA offers employee benefits that are covered under Section 125 of the Internal Revenue Service Code, which allows pre-tax deductions for certain insurance premiums. Under IRS regulations, the pre-tax elections you make annually from AURA are binding and cannot change unless you experience a Qualifying Event.

The Section 125 Plan provides tax savings by reducing employee premiums from gross salary prior to calculation of Federal and State income taxes and Social Security taxes. By taking advantage of this program via payroll deduction throughout the year, you cannot claim these same expenses on your income tax return.

A domestic partner is not a legal spouse for federal tax purposes. AURA is obligated to report and withhold taxes on the fair market value (FMV) of the domestic partner's health coverage.

Domestic partner benefits may be considered non-taxable only if the domestic partner qualifies as a "dependent" under the definition of a "qualifying relative" pursuant to Internal Revenue Code (IRC) Section 152.

Medical MetLife Expatriate Benefits

With MetLife, you have access to local resources that provide 24/7 customer service and claims processing for faster, more accurate responses and expanded network options, often referred to as Regional Service Centers. If you ever have a question or need medical assistance, simply contact Customer Service using the contact information on your ID card.

24-Hour Access to MetLife's Expatriate Benefits Service Centers

Registering for eBenefits

eBenefits is MetLife's secure, self-service web portal, available 24/7 at MetLifeExpat.com. All your policy documents — like this guide — are available on eBenefits for quick, convenient access.

Registration is easy! Now that you have your ID card, grab it and:

1. **Go** to MetLifeExpat.com and select "A member" from the dropdown menu.
2. **Click** the "New User Registration" link.
3. **Enter** your policy number, certificate number/member number, date of birth, and a valid email address. (Your policy number and certificate/member number are printed on your ID card.)

   Click Submit.
4. **Check** your inbox for a validation email and click the link in the email. The link is time-sensitive, so please access within 24 hours.
5. **Re-enter** your policy number, certificate/member number, and date of birth and click Submit.
6. **Personalize** your user profile and access eBenefits' many tools and resources.

If you cannot complete registration within 24 hours or need additional assistance, please contact your Regional Service Center.

MetLife has tools and resources to guide and support you and your family wherever you are, whether your health changes or you just want to work on getting healthier.

eBenefits

We offer many tools on our website, eBenefi ts, located at MetLifeExpat.com. Once logged in, you can:

- **Search** for full-service hospitals, medical centers, clinics, and doctors virtually anywhere in the world;
- **Submit** a claim online;
- **View** your claim history;
- **Print** a copy of your ID card or your dependents' ID cards;
- **Request** hard copies of your ID cards;
- **Update** your mailing address or employment status;
- **View** coverage details for you and your dependents;
- **Download** forms and policy information;
- **Review** travel information, such as warnings, country guides, passport and visa requirements;
- **Access** wellness tools such as health-risk assessments and personal health trackers;
- **Set** language preferences, to read in English, Spanish, Arabic, Chinese, Korean or Hindi.

Global Card

Your ID card is your key to accessing health care around the world. You and your covered dependents will each receive personalized ID cards and will share the same policy and certificate numbers.

Your ID card contains the following information:

- The logo and contact information for your **Regional Service Center**
- **Policy holder name**
- **Policy** and **certificate/member numbers**

Please carry your ID card at all times and **present it when accessing care to help minimize out-of-pocket expenses.**

Access Care

When visiting your chosen health care professional, please bring the following:

- **ID card**. When checking in, point out the Regional Service Center logo on your ID card, if you have one.
- **A form of identification**. You can use a valid national ID or passport.
- **Guarantee of Payment**, if applicable.

Health care providers anywhere in the world **should call the phone number on your ID card to verify your eligibility** or benefits. Providers should use the contact information that corresponds to their location; e.g., an international provider should use the contact information listed on the international side of your ID card and a US provider should use the contact information listed on the US side.

When to Submit a Claim

If you pay out-of-pocket, fi le a claim for reimbursement. You will be reimbursed for all covered expenses other than your patient responsibilities, like your deductible or coinsurance.

We accept claims in four convenient ways:

- **Online claim submission** via website or mobile app
- Email
- Fax
- Courier mail

No matter where you are in the world outside of the US, submit your claim form to your Regional Service Center using the contact information on your ID card. If you incur the claim within the US, send the claim to your US Regional Service Center, using the address on the US side of your ID card.

Reimbursement Options

Claims that are submitted with all of the necessary information are typically processed in 10 business days or less. Once your claim is processed, your Regional Service Center will issue a reimbursement. **Check with your Regional Service Center to see what reimbursement options are available**

MEDICAL

Plan Features	International	In Network U.S.	Out-of-Network U.S.
Deductible Individual / Family	$100 / $200		
Coinsurance	90%		
Out-of-Pocket Maximum Individual / Family	$500 / $1,000		
Lifetime Maximum	Unlimited		
In-Patient Hospital	Payable at Plan Coinsurance after deductible		
Daily Room & Board Special Care Units (ICU/CCU)	Average semi-private (Private room is covered outside the U.S. if no semi-private room equivalent is available) 2x Average. Semi-private (Private room is covered outside the U.S. if no semi-private room equivalent is available)		
Out-patient Hospital	Plan Coinsurance after deductible		
Physician Office Visits	Plan Coinsurance after deductible		
Specialists Office Visits	Plan Coinsurance after deductible		
Lab / X-Ray	Plan Coinsurance after deductible		
Prescription Drugs			
Retail Copay	Plan Coinsurance after deductible	Plan Coinsurance (Deductible Waived)	Plan Coinsurance after deductible
Mail Order	N/A	Plan Coinsurance (Deductible waived)	N/A
Mental Illness / Substance Abuse	Plan Coinsurance after deductible	Plan Coinsurance after deductible	Plan Coinsurance after deductible
Emergency Room	Plan Coinsurance after deductible	In-Network Coinsurance after In-Network Deductible	
Ambulance	Plan Coinsurance after deductible	In-Network Coinsurance after In-Network Deductible	
Well Baby / Child Care	100% (Deductible Waived)		
Adult Preventative Care	100% (Deductible Waived)		
Immunizations (Including Travel)	100% (Deductible Waived)		
Mammograms	100% (Deductible waived) per the following schedule: • *Ages 35 – 39*: one baseline exam • *Ages 40 – 49:* one baseline exam every one or two years, based upon recommendation of a Physician. • *Age 50 & Over*: one per year based on Physician's evaluation that physical conditions, symptoms or risk factors indicate a probability of breast cancer higher than the general population: one exam		

Plan Features	International	In Network U.S.	Out-of-Network U.S.
Women's Preventive Care	100% (Deductible waived) for eligible females • Annual well-woman visits (including prenatal visits) • Screening for gestational diabetes; women who are 24 to 28 weeks pregnant and at the first prenatal visit for those who are at high risk of development of gestational diabetes • Screening and counseling for interpersonal and domestic violence annually • FDA-approved contraception methods & contraceptive counseling as prescribed; including birth control & sterilization • Breast feeding support, supplies and counseling • HPV DNA testing every three years for women 30 years and older • Sexually-transmitted infection counseling and HIV screening & counseling annually		
Prostate Cancer Screening	100% (Deductible waived) once per year for eligible men age 50 and over		
Gynecological Cancer Screenings	100% (Deductible waived) once per year for eligible females		
Colorectal Cancer Screenings	100% (Deductible waived), for eligible persons age 50 and older		
Lead Screenings	Payable at 100% (Deductible waived)		
TMJ Treatment	Plan Coinsurance After Deductible up to a $1,000 per lifetime		
Applied Behavior Analysis (for treatment of autism spectrum disorder)	Plan Coinsurance After Deductible		
Infertility	Plan Coinsurance After Deductible (Covered Only to Diagnose Condition)		
Physical / Occupational / Speech Therapy	Plan Coinsurance After Deductible up to a combined 60 visits per Calendar Year		
Spinal Manipulation / Acupuncture / Acupressure	Plan Coinsurance After Deductible up to a combined 20 visits per Calendar Year		
Home Health Care	Plan Coinsurance After Deductible up to a combined 120 visits per Calendar Year		
Skilled Nursing Facility	Plan Coinsurance After Deductible up to a combined 120 visits per Calendar Year		
Inpatient Physical Rehabilitation Facility	Plan Coinsurance After Deductible up to a combined 120 visits per Calendar Year		
Hospice Care Services	Plan Coinsurance After Deductible up to unlimited		
Allergy Treatment / Testing	Plan Coinsurance After Deductible		
Alternative Therapies	Plan Coinsurance After Deductible		
Durable Medical Equipment	Plan Coinsurance After Deductible		

Plan Features	International	In Network U.S.	Out-of-Network U.S.
Diabetes Supplies	Plan Coinsurance After Deductible		
Scalp Hair Prosthesis	Plan Coinsurance After Deductible up to $500 per calendar year		
Hearing Exam	Plan Coinsurance After Deductible up to one exam every 24 months		
Hearing Aids	Plan Coinsurance After Deductible once per ear every 3 years up to $1000 per unit for dependent children up to age 24		
Second Opinion	For serious illnesses, a second Medical Opinion from specialists at top medical centers. These medical experts review the patient's medical records and provide a customized report, confirming the diagnosis and recommending a personalized treatment plan based on the latest medical research		
Vision			
Exams	100% once every 12 months (Deductible waived)		
Lenses, Frames, Hardware	100% up to $250 once every 12 months (Deductible waived)		
Global Emergency Assistance	24-hr, 7 days per week assistance services including telephonic translation, medical and legal referrals, evacuation/repatriation, dependent return, and concierge-level travel assistance. Covered at 100% (Deductible waived) up to $25,000 for Repatriation of Remains, $250,000 per occurrence for Medical Evacuation, $10,000 for Emergency Family Travel and $10,000 for Return Dependents		
Employee Assistance Program	24-hr, 7 days a week unlimited telephonic support for members including consultation, counseling and provider referral. In-person counseling for members up to 6 visits per year. Includes 24-hr, 7 days a week unlimited telephonic support for managers including with problem employees and crisis consultation		

Medical Cost

Employee and Dependents Medical premiums are pre-tax deductions, which reduce your taxable income.

	EMPLOYER MONTHLY	EMPLOYEE SEMI-MONTHLY (GEMINI)	EMPLOYEE BI-WEEKLY (NOAO/LSST/CASHR)
MEDICAL			
MetLife INTERNATIONAL			
EE Only	$482.83	$0.00	$0.00
EE + One Dependent	$801.61	$159.39	$147.13
EE + Family	$1,113.63	$315.40	$291.14

MetLife Expatriate Dental Benefits

Good dental care is essential to the maintenance of your overall health and requires regular check-ups and preventative care. Dental plans provide important insurance protection for you and your family.

Benefit Highlights	MetLife Expatriate
Annual Deductible	$25 Individual / $50 Family
Preventative	100% (Deductible waived) for Diagnostic services including oral examination, diagnostic x-rays and periodontal maintenance
Basic	80% After Deductible for Basic Restorations, Endodontics, Periodontics, Fillings, Root Canal, Scaling, Root Planning and repairs to Bridgework and Dentures
Major	50% After Deductible for Major Restorations, Dentures, Bridgework and Crowns
Annual Maximum	$2,000
Orthodontia	50% After Deductible for Child Only to age 19
Orthodontic Deductible	$25
Lifetime Orthodontic Maximum	$1,500

Dental Cost

The figures below reflect the semi-monthly cost to you for covering yourself and any dependents.

Employee and Dependent Dental Premiums are pre-tax deductions, which reduce your taxable income.

	EMPLOYER MONTHLY	EMPLOYEE SEMI-MONTHLY (GEMINI)	EMPLOYEE BI-WEEKLY (NOAO/LSST/CASHR)
DENTAL			
MetLife INTERNATIONAL			
EE Only	$37.50	$0.00	$0.00
EE + One Dependent	$87.00	$12.38	$11.42
EE + Family	$135.45	$24.49	$22.60

Global Emergency Assistance

In addition to global medical benefits, MetLife Expatriate Benefits assists in evaluation and arrangement of evacuation during medical emergencies.

Emergency Medical Evacuation Benefits

If the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while he or she is outside of his or her country of citizenship, the Insurance Company will pay for Covered Emergency Evacuation Expenses reasonably incurred, up to $250,000 for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes. An Emergency Evacuation must be ordered by the Insurance Company or a Physician who certifies that the severity or the nature of such person's Injury or Sickness warrants such person's Evacuation.

Covered expenses are those for Transportation and medical treatment, including medical services and medical supplies necessarily incurred in connection with an Insured Person's Emergency Evacuation. All Transportation arrangements made for evacuating such person must be by the most direct and economical route possible. Expenses for Transportation must be: (a) recommended by the attending Physician; (b) required by the standard regulations of the conveyance transporting such person; and (c) arranged and authorized in advance by the Insurance Company.

Repatriation of Remains

If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside his or her country of citizenship, the Insurance Company will pay for covered expenses reasonably incurred to return his or her body to his or her country of citizenship, up to $25,000.

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for Transportation of the remains; and (3) Transportation of the remains by the most direct and economical conveyance and route possible.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Emergency Family Travel

If an Insured Person is hospitalized for more than 5 days, the Insurance Company will pay up to $10,000 for the cost of round-trip economy airfare to bring a person chosen by the Insured Person to and from such Insured Person's bedside if such person is alone.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Benefits will not be provided for any expenses provided by another party at no cost to the Insured Person.

Return of Dependents

If an Insured Person is hospitalized for more than 3 days, the Insurance Company will pay up to $10,000 for the cost of economy airfare for Transportation of the Insured Dependent to his or her country of citizenship or otherwise designated location. This will include an escort to accompany an otherwise unaccompanied minor Dependent Child during the journey.

The Insurance Company must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Insurance Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact the Insurance Company in advance.

Benefits will not be provided for any expenses provided by another party at no cost to the Insured Person.

Employee Assistance Program

Brought to you by PPC Worldwide. Making life run more smoothly.

Expatriate employees and their families experience a unique type of stress that comes with planning relocation, adjusting to new surroundings and leaving familiar sources of support behind. This is why MetLife Expatriate Benefits offers counseling and support services to all of the expatriates we insure. You are only a phone call away from independent advice, information and support that is completely confidential and at no cost to you.

You're supported worldwide:

- Available 24 hours a day, 7 days a week, 365 days a year
- Access to 6 in-person sessions with a counselor
- Unlimited telephonic support
- Access worldwide by phone, email or web
- Provides information, resources, and counseling on any work, life, personal, or family issue that matters to you.
- No cost to you to use the service

Brought to you by PPC, this Employee Assistance Program (EAP) is available to you and your family household members any time, day or night, on any day of the year. Over the last 35 years, PPC has built up an international reputation as a leading provider of professional advice and counseling to organizations and their employees.

How can you access MetLife's IEAP services?

Call the 24/7 helpline: +44 1865 397 074

Interpreters and telephone call-back arrangements are available – all counseling is provided by local professionals near your home or place of work.

You can visit PPC's website for useful information and fact sheets on health, personal support, and work/life balance for expatriates. Find a link through MetLife's secure, self-service website, eBenefits, located at www.MetLifeExpat.com. Or, visit PPC directly at www.PPConlineinfo.com.

Use the following access code to login:

Access code: metlifeexpat

Flexible Spending Accounts

Only employees that are a U.S. Citizen/Resident are eligible to participate.

AURA offers Flexible Spending Accounts (FSAs) through TASC. FSAs allow you to save money on a pre-tax basis to pay for your family's qualified out of pocket healthcare (medical, prescription, dental, and vision) and dependent care (child and elder care companion services).

FSAs allow you to save money because your contributions to the accounts are deducted from your paycheck before Federal and Social Security taxes are calculated. The amount of savings you will enjoy by participating in an FSA will depend on your individual tax bracket and the amount of money that is withheld from your paycheck on a tax-free basis. For example, an individual in the 15% tax bracket will save approximately $0.23 on each dollar. The above savings example is derived from 15% federal income tax and 7.65% Social Security (FICA) tax, which equals 22.65%. Depending on where you live, you may also save on state and local income taxes *(see the tax savings example on the next page)*

TAX SAVINGS EXAMPLE		
	With FSA	Without FSA
Gross Salary	$35,000	$35,000
Health / Day Care Expenses (Pre-Tax)	($1,200)	(N/A)
Taxable Income	$33,800	$35,000
Tax (25%)	($8,450)	($8,750)
Net Salary	$25,350	$26,250
Health / Day Care Expenses (After-Tax)	(N/A)	($1,200)
Take Home Pay	$25,350	$25,050
TAX SAVINGS:	**$300**	**N/A**

An FSA is an account with automatic deposits of payroll deductions. Here is how it works:

1. You decide in advance how much to contribute to each account each plan year.
2. Your contributions are automatically withheld in equal amounts from your paychecks throughout the year before taxes are applied. Your contributions will be credited to an account(s) in your name.
3. The full election amount in a Healthcare FSA is available for reimbursement at the beginning of the plan year.
    a. With a Dependent Care FSA account, a participant's reimbursement may not exceed the balance in the FSA account at the time the claim was made.
4. You incur expenses as you normally would. Then you submit your itemized statement or Explanation of Benefits (EOB) with a claim form for reimbursement.
    a. Or, for certain qualified expenses, you may be able to use a Debit Card for direct access to the funds (though you are required to retain your itemized receipts for substantiation).
5. Reimbursements are tax-free so you never pay taxes on the money you set aside!
6. If you do not use your funds by the end of the plan year, **you can roll-over up to $500 into the next plan year**. If you have more than $500 in unused funds, they will be forfeited to the account under the IRS' "Use it or Lose it" provision.

Healthcare FSAs

A Healthcare FSA is designed to help you pay for eligible expenses that are not covered by your basic health plan, as well as any deductible amounts you have to pay and co-pays or coinsurance amounts required for services covered by your insurance plan. Eligible expenses also include many services that may not be covered by your medical, dental, or vision plan, for example deductibles, copays, braces, eyeglasses, etc. Please refer to IRS publication 502 for a full list of qualified expenses.

When calculating your estimated out-of-pocket expenses, please keep in mind that you are able to get reimbursed for out-of-pocket medical expenses for your spouse, child and any dependent who is a "qualifying child" or relative. You can contribute any amount up to a maximum of $2,600 for 2017.

Dependent Care FSAs

The Dependent Care FSA lets AURA's employees use pre-tax dollars towards qualified dependents care such as caring for children under the age 13, care of children 13 or older who are mentally or physically incapable of self-care, or caring for elders. To decide whether a Dependent Care FSA is right for you, determine if you will incur eligible expenses. Generally, child and elder care companion services are eligible expenses, as are Social Security and other taxes you pay a caregiver.

Eligible dependent care expenses may be reimbursed through a FSA (up to $5,000 per calendar year or $2,500 if married and filing separately) or used to obtain a Federal tax credit on your income taxes. You cannot use both options for the same expenses, and typically, greater savings can be achieved through the FSA.

Every dollar reimbursed through your Dependent Care FSA reduces, dollar-for-dollar, your maximum eligible expenses under the Federal tax credit. Depending on your individual tax bracket, you may be entitled to include a maximum of $3,000 a year in expenses under the Federal tax credit if you have one qualifying dependent and $6,000 a year in expenses if you have two or more qualifying dependents. Please review with your tax advisor to see which option is best for your and your family.

Basic Life and AD&D Benefits

AURA has contracted with Cigna to provide Basic Life and Accidental Death and Dismemberment (AD&D) insurance for employees. All Regular Full-Time and Part Time employees scheduled to work at least 20 hours per week are eligible for coverage.

Group Life	Full-Time Employees	Part-Time Employees
Life Coverage	1x annual base salary to a max of $250,000 with a minimum of $50,000	1x annual base salary to a max of $250,000 with a minimum of $25,000
AD&D	Match Life coverage	Match Life coverage

Life and AD&D

- Benefit level is reduced to 65% at age 75 and to 50% at age 80.
- Accelerated Benefits are available if diagnosed with a terminal illness
- Will Preparation Assistance
- Portability Option
- Travel Assistance

AURA pays 100% of the cost for Basic Term Life and AD&D coverage.

Voluntary Term Life and AD&D Benefits

Eligible employees are also able to purchase additional life and AD&D insurance for yourself, your spouse, and/or your children. Rates are based on Employee's age as of January 1st and the amount of coverage selected. During initial eligibility, coverage is guaranteed issue up to specified limits. All elections above the guaranteed issue amount or outside of initial eligibility are subject to Evidence of Insurability (Statement of Health).

If you are currently enrolled for less than the Guarantee Issue Amount, you can increase your coverage $10,000 without Evidence of Insurability during Open Enrollment.

- Employees (Guarantee Issue amount: $100,000):
  - You may elect coverage in $10,000 increments up to a maximum of $500,000 or 7x annual base salary (whichever is less)
- Spouses (Guarantee Issue amount: $30,000):
  - Rates based on Spouses age as of January 1st
  - Spouse coverage is available up to age 70
  - You may elect coverage in $10,000 increments up to a maximum of $150,000.
- Children (Guarantee Issue amount: $10,000):
  - 14 days to 6 months coverage of $500
  - 6 months to 26 coverage of $10,000

Voluntary Life Cost

Rates per $1,000	EE Smoker	EE Non-Smoker	Spouse
Ages <25	$0.127	$0.067	$0.060
Ages 20-24	$0.127	$0.067	$0.060
Ages 25-29	$0.127	$0.067	$0.075
Ages 30-34	$0.142	$0.075	$0.097
Ages 35-39	$0.180	$0.097	$0.112
Ages 40-44	$0.292	$0.157	$0.120
Ages 45-49	$0.502	$0.262	$0.180
Ages 50-54	$0.862	$0.427	$0.285
Ages 55-59	$1.410	$0.757	$0.525
Ages 60-64	$1.627	$0.930	$0.810
Ages 65-69	$2.692	$1.657	$1.552
Ages 70-74	$4.207	$2.805	$1.552
Ages 75-79	$4.207	$2.805	$1.552
Ages 80-84	$4.207	$2.805	$1.552
Child(ren)			
$1.20 for $10,000 Coverage for Eligible Child(ren)			

Voluntary AD&D Benefits

- Voluntary Employees:
  - $10,000 increments to a max of $500,000
- Spouses (coverage only available up to age 70):
  - $10,000 increments to a max of $250,000

Voluntary AD&D Cost

Rates per $1,000	Employee	Spouse
Employee	$0.02	$0.02
Family	$0.02	$0.02

Disability Benefits

AURA understands that for most of us our income is the most important financial resource. To be without income for an extended period of time would most likely be devastating for you and your family. We recognize the importance of protecting your income against the possibility of long term disability. AURA has contracted with Cigna to provide disability coverage for employees at no cost to the employee. The Short and Long Term Disability plans provide replacement of a portion of an employee's income, if they have to be out of work due to an off the job illness or injury.

Short Term Disability

- Replaces 60% of your weekly base salary, up to a maximum of $1,385 per week, if you are unable to work due to an illness or off-the-job injury
- Benefits begin;
    - NOAO/LSST/CASHR: later of 50% of accumulated sick leave or after 13 days of an illness/injury
    - Gemini: after 13 days of an illness/injury
- Once you qualify for benefits, you continue to receive them until the end of the 26 week benefit period, or until you no longer qualify for benefits, whichever occurs first.

AURA pays 100% of the premium for all full-time employees.

Long Term Disability

- Replaces 60% of your monthly base salary, up to a maximum of $6,000 per month, if you are unable to work and suffer a loss of income due to an accident or illness
- Benefits begin after an elimination period of 180 days and will continue until your social security retirement age, or until you no longer qualify for benefits, which ever occurs first.
- Benefit Period: If your disability occurs at or after age 65, benefits would be paid for a reduced period of time.
- Cost of Living Adjustment (COLA): 3%
- Retirement Savings: 10% (Calculated on base salary)
- Mental & Nervous Benefit Period: Is limited to 24 months unless you are confined in a hospital.
- Pre-Existing Condition: Limitation is applicable to this coverage for new enrollees. Namely, if you have received treatment for any condition three months prior to your coverage effective date, you will need to be treatment-free for 12 months from your effective date before benefits will be paid for the pre-existing condition.

AURA pays 100% of the premium for all full-time employees.

401(a) Money Purchase Pension Plan

The Money Purchase Pension Plan (MPPP)--401(a) is a retirement plan for employees of AURA. The retirement plan is a part of AURA's total compensation package and is intended to help provide retirement income to its employees.

As a Regular Full-time or Regular Part-time AURA employee you are eligible to participate in the 401(a) retirement plan. Employees may participate in the Plan upon date of hire.

The 401(a) Plan is funded entirely by employer contributions. AURA will contribute on a biweekly basis an amount equal to 10% of your base salary for the pay period. Employees are immediately vested at 100%. Upon completion of employment, you may elect: (1) to leave the money on deposit and withdraw it later in the form of annuity payments or cash (except TIAA as described below); (2) or you may elect to receive it at the time of termination, with certain tax implications.

There are two investment companies that you have the option of selecting to invest with: Fidelity Investments and Teachers Insurance Annuity Association/College Retirement Equity Fund (TIAA/CREF.) You may select from the funds offered within each company's plan and reallocate among the funds according to the terms of the Plan. If you decide at a later time to have funds deposited with the other company, you have flexibility; (funds deposited with TIAA/CREF's Traditional Annuity accounts may only be transferred or withdrawn in ten annual installments).

To enroll in the program, you must complete the Money Purchase Plan Enrollment Form and the Fidelity or TIAA/CREF Application Form and return to the Human Resources Office.

You have 31 days from your date of eligibility to make your investment company selection. After 31 days, your retirement company election will automatically default to Fidelity Investments and your investment allocations will be made to the applicable Fidelity Freedom K® Fund.

This is only a summary of the Plan, for more information regarding each company's provisions and enrollment documents please contact the Human Resources Office.

Finally, participation in this Plan provides certain tax benefits and liabilities. We suggest you consult your tax professional for advice.

403(b) Tax Sheltered Annuity

Only employees that have reportable income in the US are eligible to participate. Third country nationals without taxable income are not eligible to participate.

As an employee of AURA, a not-for-profit research institution, you are eligible to establish a 403(b) Tax Sheltered Annuity (TSA). This account is distinct from your AURA 401(a) Money Purchase Pension Plan account.

The TSA is funded entirely through pre-tax or post-tax (Roth) employee contributions. The amount of money you may contribute is calculated according to IRS regulations. Most employees may not contribute more than $18,000 per year (for the year 2017). Certain "catch-up" provisions allow those over 50 years of age who meet certain eligibility qualifications to set aside an additional $6,000 (for year 2017). It is important for you to know that there may be limits on the total of all your tax deferred compensation plans. You should consult a tax professional regarding your individual situation and the limits that apply. You may elect to contribute any amount up to your maximum.

You may invest your contributions in funds offered to AURA employees by either Fidelity Investments or Teachers Insurance Annuity Association/College Retirement Equity Fund (TIAA/CREF.). Both companies offer a broad assortment of investment opportunities, ranging from aggressive to conservative. Be sure to review the companies' web sites, fund prospectuses (often available online), and other literature before making investment decisions. You have the flexibility to make changes to the funds or direct future funds to the other company.

There are provisions for borrowing against your TSA if the funds are deposited with TIAA/CREF. Loans are not allowed from the accounts with Fidelity Investments.

In regard to withdrawals, pre-tax contributions and their earnings will be taxable at withdrawal. Post-tax (Roth) contributions and their earnings are untaxed in retirement if you participated for at least 5 years and are age 59½. An additional penalty will be assessed if you withdraw the funds prior to age 59 ½.

As with any issue involving your individual tax situation, we suggest you consult with your tax professional.

Retirement Program Summary

	Money Purchase Pension Plan – MPP (401A) Regular Retirement Account	Supplemental Retirement Account – SRA (403B) Tax Sheltered Account
Eligibility	Date of Hire (effective 1/1/2010)	First day of any pay period coincident with or following date of hire.
Vesting	100% immediately upon participation.	
Investment Vendors	TIAA-CREF or Fidelity Investments	
Contributions	Employer only	Employee only
Amount	10% of base salary. Contributions are made biweekly at the close of the pay period in which they are earned. The maximum amount that may be contributed to this plan is $50,000.	Maximum contingent upon IRS regulations.* Employees may contribute the IRS determined maximum. An additional catch-up contribution is allowed for those 50 and older. ($18, 000/$6,000 IRS limits for 2017).
Tax Status of Contributions	You are not taxed on the contributions made on your behalf.	Traditional 403(b) contributions will reduce your taxable income. Roth 403(b) contributions will be made with salary for which taxes have been assessed.
Tax Status of Withdrawals	All contributions and their earnings will be subject to taxes at withdrawal. An additional penalty will be assessed if you withdraw the funds prior to age 59 ½.	Traditional, pre-tax contributions and their earnings will be taxable at withdrawal. Roth 403(b) contributions and their earnings are untaxed in retirement if you participated for at least 5 years and are age 59 ½. An additional penalty will be assessed if you withdraw the funds prior to age 59 ½.
Withdrawal Provisions	No in-service withdrawals except less than full-time employees age 62 or older. Upon termination, lump sum withdrawal subject to 10% early withdrawal penalty and federal and state taxes if not rolled-over to another qualified plan. Some restrictions apply to TIAA-CREF traditional funds.	No in-service withdrawals, except full or partial withdrawals for defined hardships, subject to 10% early withdrawal penalty and Federal and state taxes.
Portability	May continue with future employer if future employer has a similar plan and allows rollovers into their Plan.	Full transfer to other 403(b), IRA, 401(k) permitted. May rollover qualified pension contributions from previous employer.
Loan Provisions	None on MPP.	Loans are permitted for TIAA/CREF plans only. Loans are limited by federal guidelines and the rules of the investment company.
Transfers	Transfer of existing funds from one investment company to another at any time (providing you have an open account); subject to any and all fees imposed by respective investment companies. Frequency of transfer of funds within active accounts TIAA-CREF unlimited. Fidelity generally unlimited.	
Change In Investment	Change from one investment company to the other anytime during the year. Changes in allocation of future contributions among funds within Fidelity are unlimited. TIAA-CREF is once a month.	Employees may cancel, increase, or decrease their contributions at the beginning of any pay period, as well as transfer from one investment company to the other at any time throughout the year. Transfer of funds within TIAA-CREF and Fidelity same as MPP.

Paid Time Off

Sick Time

Eight hours worth of sick leave are accrued per month during the first year; 13.5 hours per month are accrued during the second and third years of employment and 20 hours per month thereafter. Sick leave does not accrue during leave without pay. No more than 1,440 hours worth of sick leave may be carried forward to a new calendar year. Temporary and part-time employees who work at least 20 hours per week receive proportionate sick leave credit and may carry to the following year in proportion.

Vacation

Vacation leave accrues at the rates below for regular full-time employees. Regular part-time employees scheduled at least 20 hours per week accrue a proportionate rate based on scheduled hours. Vacations are to be taken at the convenience of the observatory and normally require advanced approval.

Non-Exempt Employees		
Years of Service	Hours/Month	Bi-Weekly Accrual
1-2	8	3.69 hours
3-5	12	5.53 hours
5 and over	16	7.38 hours
Exempt Employees		
16 hours per month from date of hire		

Holidays

Each year Human Resources in consultation with the AURA-O director will publish a Holiday calendar with the designated holidays in Chile.

Part-time employees receive the same holidays, as do full time employees. They are paid in direct proportion to the average number of hours worked per day during the previous pay period if they have worked at least 40 hours or more during that pay period.

Holidays occurring during vacation or sick leave will be paid and not charged against vacation or sick leave. However, holiday pay is not granted during vacation in conjunction with retirement or termination from employment. Holidays occurring during leave without pay will not be paid.

Tuition Reimbursement

We support work-related education and training for regular, full-time employees, by refunding up to 100% of tuition cost for grades of A or B and up to 50% for a grade of C. Each center may designate an annual reimbursement limit.

Reimbursements are limited to six credits per semester. Approval must be obtained in advance of registering. Employees eligible as veterans for benefits under G.I Bill, or similar legislations, shall be reimbursed for not more than the amount by which the tuition fee exceeds the benefits to which the employee is already entitled. According to Internal Revenue Code regulations, reimbursement for certain courses, or for payments above established amounts in any calendar year, is considered taxable income.

This is only a summary of the benefit, for more information regarding tuition reimbursement please contact the Hunan Resources Office.

Frequently Asked Questions

What is a Deductible?

The amount of money that you must pay first pay toward health or dental expenses for each family member, each calendar year, before the health or dental plan will pay for eligible benefits. Deductible amounts vary based on whether you use In-Network or Out-of-Network providers or facilities. Some services may not require a deductible before claims are paid (i.e. preventive care or co-pay related services).

What is Co-Insurance?

The cost-sharing responsibility between a member and the health plan after you pay the deductible. Once you have satisfied the deductible, you will pay a percentage of the expenses until you reach the plan out of pocket maximum.

What is a Copayment?

Also known as a "co-pay", a fixed dollar amount paid for certain services (i.e. office visit, urgent care visit, prescription drug, etc.). The remaining cost is covered by the health plan.

What is a PCP/Specialist?

A primary care physician (PCP) is a general or family practitioner, internal medicine doctor or pediatrician (and in some cases Gynecologists). All other physicians are considered specialists. No referral is needed to see a specialist on your plan.

What is an In-Network Provider?

In-network providers have a contract with the insurance carrier to accept reduced fees for services rendered to plan members. Using in-network providers will cost you less money. MetLife International have in-network providers.

What is an Out-of-Network Provider?

Out-of-network providers DO NOT ACCEPTS contracted fees. This means you could be charged the difference between what the provider charges and the maximum the insurance company will pay for specific services. This additional amount charged does not apply towards your deductible, coinsurance, and/or out-of-pocket maximum.

The benefit deductible and coinsurance on the medical plan are significantly different when using out-of-network versus in-network providers.

When should I go to the Emergency Room?

If you think you or a family member may be experiencing an emergent medical condition, you should go to the nearest emergency room or call 911. An emergent medical condition is any condition (including severe pain) which you believe lack of immediate medical care may result in:

- Serious jeopardy to your health
- Serious impairment to your bodily functions
- Serious dysfunction of any of your bodily organs

Examples of emergency conditions:

- heavy bleeding
- chest pain
- severe head injury
- large open wounds
- major burns
- difficulty breathing
- sudden change in vision
- spinal injury
- sudden weakness or trouble walking

How are emergencies covered?

Emergency health services are always paid at in-network benefit levels. However, if an emergency service provider is out-of-network, the provider will be reimbursed on the contracted fee schedule. You are responsible for the difference between the amount billed by the provider and the amount your plan allows for reimbursement.

What is Prior Authorization?

Some services require prior authorization (also referred to as precertification). In general, in-network physicians and other health care professionals are responsible for obtaining prior authorization. However, if you choose to receive services from out-of-network providers, you are responsible for obtaining authorization before you receive the services. Refer to the AURA's Certificate of Coverage for more detailed information.

What does Reasonable and Customary mean?

It is the lowest of:

- the usual charge by the doctor, dentist or other provider of the services or supplies for the same or similar services or supplies,
- the usual charge of most other doctors, dentists or other providers of similar training or experience in the same geographic area for the same or similar services or supplies, or the actual charge for the services or supplies.

Important Information

COBRA

COBRA is a U.S. law that applies to employers in the U.S. with more than 20 employees. If your employer pays U.S. withholding tax related to your employment, you are eligible for COBRA continuation coverage when a qualifying event occurs.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continue coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision coverage because you terminate employment (for reason other than gross misconduct), your work hours are reduced below the eligible status for these benefits, you die, divorce, or are legally separated, or a child ceases to be an eligible dependent.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions that protect the privacy of health plan participants. These provisions, which went into effect April of 2003, govern how covered entities such as health insurance companies and the plan sponsor must handle protected health information. The company distributes HIPAA Privacy Notices in accordance with Federal regulations. If you need to obtain a copy of the HIPAA Privacy Notice please contact Human Resources.

GINA

The Genetic Information Nondiscrimination Act (GINA) states that under a 2009 federal law, group health plans are prohibited from adjusting premiums or contribution amounts for a group on the basis of genetic information. A health plan is also prohibited from requiring an individual or his/her family member to undergo a genetic test, although the plan may request that a voluntary test be taken for research purposes.

Mental Health Parity

In 2009, the Wellstone Act added to the requirements of the 1996 Mental Health Parity Act (MHPA). The new act has extended parity requirements to substance use disorder benefits in addition to mental health benefits. It prohibits applying financial requirements (e.g. copayments and deductibles) or treatment limitations (e.g. annual limits on outpatient visits or hospital days) to mental health or substance use disorders unless those requirements and limitations are no more restrictive than those that apply to most medical and surgical benefits. The act also maintained the MHPA's ban on lower annual or lifetime dollar limits for mental health benefits.

Michelle's Law

Michelle's Law is a federal law that allows continued coverage for seriously ill college students. A college student will be able to maintain health plan eligibility for up to one year after full-time student status is lost due to a medically necessary leave of absence from school. "Michelle's Law" was named after New Hampshire college student Michelle Morse, who, despite being diagnosed with cancer, attended school full-time to stay enrolled in her parents' health insurance.

Newborn's & Mother's Health Protection Act

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 a 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 other, 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patient benefits for:

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

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact the Human Resources Department.

Contact Information

MetLife Expatriate Benefits Medical / Dental / Vision		www.metlifeexpat.com
Care outside of the USA US: +1-913-814-6142 Outside of the US: +1-302-661-8674 Email: wilclaims.metlifeexpat@alico.com		
TASC Flexible Spending Accounts	(800) 422-4661	www.tasconline.com
CIGNA Group Insurance Life, AD&D, and Disability	(800) 901-7534	www.cignawillcenter.com (Will Prep)
Fidelity Investments Financial & Retirement Consultant	(800) 343-0860	www.fidelity.com
TIAA-CREF Financial & Retirement Consultant	(800) 842-2776	www.tiaa-cref.org
AURA HR	Yura Monsanto +56 51 2205306 ymonsanto@aura-austronomy.org	D'Andrea Williams (520) 318-8158 dwilliams@aura-astronomy.org
Catherine Nault Lovitt & Touche Claims Advocate	(520) 722-7155 (Tucson) (866) 532-7516 (Statewide)	cnault@lovitt-touche.com

Prepared by:

Lovitt & Touché

About this Booklet. This booklet highlights important features of your company's benefits for its employees. While eff orts have been made to ensure the accuracy of the information presented, in the event of any discrepancies your actual coverage and benefits will be determined by the legal plan documents and the contracts that govern these plans. Benefit plans may be changed for any reason, to the extent allowed by law. Your participation on in these benefits is not a contract of employment and does not guarantee future employment.

Notes