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Benefits Guide

For Employees at

Daniel K. Inouye Solar Telescope

DKIST
DANIEL K. INOUYE SOLAR TELESCOPE

2017

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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 and Dental Insurance
- Flexible Spending Accounts (FSA)
- Basic Term Life and Accidental Death and Dismemberment Insurance
- Voluntary Term Life and Accidental Death and Dismemberment Insurance
- Hawaii Temporary Disability Insurance
- Supplemental 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
  - HMSA: Date of hire
- 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 eligible employee only HMSA Medical and Dental coverage. Employee shares in the cost for Kaiser medical, dependent medical and dental coverage. AURA pays the full cost of Basic Life/AD&D, Hawaii Temporary Disability Insurance, Supplemental STD and LTD coverage. 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 Benefits

AURA has contracted with HMSA and Kaiser to provide Medical Plan benefits. Both HMSA and Kaiser have a Health Maintenance Organization (HMO) Plan and Preferred Provider Organization (PPO) Plan to choose from. When using in-network providers, you get the best value of your healthcare dollar.

Members enrolled on a PPO Plan can access service from providers outside the network; however, these services are reimbursed at a lower level and have additional out of pocket costs; such as deductibles, co-insurance, and balance billing for expenses beyond the reasonable and customary cost for treatments. Please refer to your plan documents for additional information on coverage for out of network services.

MEDICAL – HMSA HMO & Comp Care

Benefits Highlights	In-Network ONLY
Deductible	None
Out-of-Pocket Maximum Individual/ Family	$2,500 / $7,500 (medical) $3,600 / $4,200 (pharmacy)
Office Visit Copay	$20 copay
Preventive Care	No charge
Emergency Room	20% coinsurance
Chiropractic/ Acupuncture / Massage Therapy	$20 copay, 12 visit maximum using ASH participating providers
Diagnostic Lab	20% inpatient; 20% outpatient
Diagnostic X-Ray	20% inpatient; 20% outpatient
Diagnostic Imaging (MRI / PET / CAT)	20% inpatient; 20% outpatient
Inpatient Hospital	20% coinsurance
Prescription Drugs	
Retail Copay	$7 generic $30 preferred brand $75 copay other brand $100 preferred $200 other specialty brand
Mail Order	$11 generic $65 preferred brand $200 copay other brand Specialty not offered

- Must choose a Health Plan Center and Primary Care Provider
- Referral required from PCP for services provided by other healthcare providers
- Acupuncture, chiropractic care, & massage therapy available thru COMPREHENSIVE CARE (American Specialty Health) questions can be directed to (800) 678-9133; Option #3

Vision Benefits

VISION – HMSA HMO & Comp Care Vision Adult Benefits – *Member Responsibility*

Benefit Highlights	In-Network	Out-of- Network
Eye Exam Once per calendar year	$10 copay	Not Covered
Lenses (Single) Once per calendar year	$10 copay	100% less $16 reimbursement
Frames (Designated Group) One every 24 months	$15 copay- from a chosen group. Any frame outside that group, the member pays the difference.	100% less $12 reimbursement
Contacts	$25 copay up to $130 maximum	Fitting $45 maximum

VISION-HMSA HMO & Comp Care Vision Children thru age 18 – Member Responsibility

Benefit Highlights	In-Network	Out-of- Network
Eye Exam Once per calendar year	$10 copay	Not Covered
Lenses (Single) Once per calendar year	$10 copay	50% of eligible charge
Frames (Designated Group) One every 24 months	$15 copay- from a chosen group. Any frame outside that group, the member pays the difference.	50% of eligible charge
Contacts	Up to 50% of eligible charge	

MEDICAL – HMSA PPO & Comp Care

Benefit Highlights	In-Network	Out-of-Network
Deductible Individual / Family	$300 / $900	
Out-of-Pocket Maximum	$3,000 / $9,000 (medical) $3,600 / $4,200 (pharmacy)	
Office Visit / Urgent Care Copay	$17 copay	30% after deductible
Preventive Care	No Charge	30% after deductible
Emergency Room	20% after deductible	
Diagnostic Lab and X-Ray	20% after deductible	30% after deductible
Diagnostic Imaging (MRI / PET / CAT)	20% after deductible	30% after deductible
Acupuncture, chiropractic care & massage therapy	$20 copay up to a combined maximum of 12 visits per calendar year thru CompCare (American Specialty Health)	50% up to a maximum $30 per visit to a combined maximum of 12 visits per calendar years thru CompCare
Inpatient Hospital	20%	30%
Prescription Drugs	$7 generic $30 preferred brand $75 copay other brand $100 preferred $200 other specialty brand	$7 + 20% generic $30 + 20% preferred $30 + 20% non-preferred brand Specialty not covered
Mail Order Prescription Drugs	$11 generic $65 preferred brand $200 copay other brand Specialty not offered covered	Not Covered

Vision Benefits

VISION – HMSA PPO & Comp Care Vision Adult Benefits – *Member Responsibility*

Benefit Highlights	In-Network	Out-of- Network
Eye Exam Once per calendar year	$10 copay	Not Covered
Lenses (Single) Once per calendar year	$10 copay	100% less $16 reimbursement
Frames (Designated Groups) One every 24 months	$15 copay- from a chosen group. Any frame outside that group, the member pays the difference.	100% less $12 reimbursement
Contacts	$25 copay up to $130 maximum	Fitting $45 maximum

VISION- Children thru age 18 – Member Responsibility

Benefit Highlights	In-Network	Out-of- Network
Eye Exam Once per calendar year	$10 copay	Not Covered
Lenses (Single) Once per calendar year	$10 copay	50% of eligible charge
Frames One every 24 months	$15 copay- from a chosen group. Any frame outside that group, the member pays the difference.	50% of eligible charge
Contacts	Up to 50% of eligible charge	

MEDICAL – Kaiser HMO

Benefits (Member Responsibility)	Kaiser Facility
Deductible	N/A
Coinsurance	10%
Out-of-Pocket Maximum Individual/ Family	Includes coinsurance and copays (Med & Rx) $2,500 / $7,500
Office Visit Copay	$20 copay
Preventive Care	$0
Retail / Convenience Clinic	$20 copay
Urgent Care	$20 copay
Emergency Room	$100 copay
Chiropractic Care	$20 copay
Diagnostic Lab	$10 copay
Diagnostic X-Ray	$10 copay
Diagnostic Imaging (MRI / PET / CAT)	20% coinsurance
Inpatient Hospital	10% coinsurance
Outpatient Hospital	10% coinsurance
Prescription Drugs (In-Network) Deductible Retail Copay Specialty Copay 3 Month Mail-Order Copay	 None $3 / $10 / $45 copay $200 copay $6 / $20 / $90 copay / Specialty N/A

- Services are provided at a Kaiser facility only.
- $1,000 allowance for primary care office visits by non-Kaiser providers, subject to applicable copays
- Preventative and routine care with out-of-state primary is covered for all full time college students attending college outside of the Kaiser Service area and within the U.S.

Vision Benefits

Kaiser HMO VISION/ALTERNATIVE MEDICINE/ACTIVE & FIT

Benefit Highlights	In-Network
Optical 150 (Vision)	All costs greater than a $150 allowance once every calendar year for glasses OR contact lenses
Alternative Medicine	Coordinated by a Kaiser physician, but not required. Call 800-678-9133 for participating American Specialty Health Networks providers or login at www.ashlink.com. Your user ID and PIN are in your Welcome Letter or you can request it on the site (forgot ID/ forgot password)
Chiropractic/Acupuncture/Massage Therapy	$20 copay, 12 visits per calendar year
Active & Fit	$100 per calendar year gym membership or $10 per calendar year home fitness program

MEDICAL – Kaiser Added Choice

Benefit Highlights	In-Network	Out-of-Network
Deductible (Calendar)	Non-Embedded	
Individual / Family	None	$100 / $300
Coinsurance	10%	
Out-of-Pocket Maximum Individual / Family	Applies to supplemental charges as defined in the Plan Summary $2,000 / $6,000	
Office Visit / Urgent Care Copay	$20 copay	20% coinsurance
Preventive Care	$0	
Retail / Convenience Clinic	$20 copay	20% coinsurance
Urgent Care	$20 copay	20% coinsurance
Emergency Services	$75 copay	
Chiropractic Care	$20 copay	
Diagnostic Lab	10% coinsurance	20% coinsurance
Diagnostic X-Ray	10% coinsurance	20% coinsurance
Diagnostic Imaging (MRI / PET / CAT)	10% coinsurance	20% coinsurance
Inpatient Hospital	$75 copay per day	20% coinsurance
Outpatient Hospital	$20 Copay	20% coinsurance
Prescription Drugs (In-Network)	Kaiser Provider	Contracted Provider
Deductible	None	
Retail Copay	$3 / $10 / $45 copay	20% not less than: $10 / $10 $45
Specialty Rx	$200 Retail	20% not less than $200
3 Month Mail-Order Copay	$6 / $20 / $90 copay / Spec N/A	20% not less than: $10 / $10 / $45

- Out-of-Network benefit payments are based on the Maximum Allowable Charge (MAC). It is lesser of (1) the usual & customary; (2) the negotiated rate; or (3) the actual billed charges.
- Members are responsible for charges that exceed the MAC
- Coverage for routine, continuing and follow-up primary care for out-of-state full time college students attending college outside of the Kaiser Service area and within the U.S.

Vision Benefits

Kaiser Added Choice VISION / ALTERNATIVE MEDICINE / ACTIVE & FIT

Benefit Highlights	In-Network	Out-of-Network
Optical 150 (Vision)	All costs greater than a $150 allowance once every calendar year for glasses OR contact lenses	$50 total allowance for lenses, frames, and contacts.
Alternative Medicine	Coordinated by a Kaiser physician, but not required. Call 800-678-9133 for participating American Specialty Health Networks providers or login at www.ashlink.com. Your user ID and PIN are in your Welcome Letter or you can request it on the site (forgot ID/ forgot password)	
Chiropractic/Acupuncture/Massage Therapy	$20 copay, 12 visits per calendar year	
Active & Fit	$100 per calendar year gym membership or $10 per calendar year home fitness program	N/A

Medical Cost

The figures below reflect the bi-weekly cost to you for covering yourself and any dependents with AURA paying 100% of the Employee premium and 50% of the Dependent premium (Spouse includes domestic partner) for the HMSA HMO – Health Plan Hawaii Plus, you are responsible for the difference in cost for the Kaiser plans.

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

	TOTAL MONTHLY	EMPLOYER PREMIUM		EMPLOYEE PREMIUM	
	PREMIUM	Bi-weekly	Weekly	Bi-weekly	Weekly
MEDICAL					
Health Plan Hawaii (HMO)- HPH B					
EE Only	$378.58	$174.73	$87.36	$0.00	$0.00
EE + One Dependent	$757.14	$262.09	$131.04	$87.36	$43.68
EE + Family	$1,135.32	$349.36	$174.68	$174.63	$87.32
Preferred Provider Plan (PPO)-PPP B					
EE Only	$349.92	$161.50	$80.75	$0.00	$0.00
EE + One Dependent	$699.82	$242.25	$121.12	$80.75	$40.37
EE + Family	$1,049.34	$322.91	$161.45	$161.40	$80.70
Kaiser HMO					
EE Only	$458.19	$211.47	$105.74	$0.00	$0.00
EE + One Dependent	$916.38	$317.21	$158.60	$105.74	$52.87
EE + Family	$1,374.58	$422.95	$211.47	$211.47	$105.74
Kaiser Added Choice					
EE Only	$649.48	$299.76	$149.88	$0.00	$0.00
EE + One Dependent	$1,298.96	$449.64	$224.82	$149.88	$74.94
EE + Family	$1,948.38	$599.51	$299.75	$299.75	$149.87

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. AURA offers you two dental plans to choose from, HMSA's Dental HMO or PPP Dental.

The HMSA Dental HMO is an **In-network ONLY** insurance service. This chart gives amounts you are responsible for if you enroll in the Dental HMO Plan.

HMSA Dental HMO L95

Benefit Highlights	HMSA Dental Network Provider ONLY
Calendar year Maximum	None
Calendar Year Rollover	Not Applicable
Deductible	None
Preventive Care	
Exams	$0
Cleaning	$0
Topical Fluoride	$0
X-Rays	$0
Routine Care	
X-rays - Periapical	$0
Fillings	$10 per tooth
Sealants on permanent molars	$0
Space Maintainers	$25 per procedure
Endodontics	$15 per tooth
Periodontics	$75 for gingivectomy for 4 or more contagious teeth $10 for 1 to 3 teeth
Major Care	
Waiting Periods – New Members	12 month for Bridges, Dentures & Crowns
Crowns, Bridges	$100 High noble metal
Dentures	$150 per denture
Partial upper or lower denture	$150 per denture
Complete upper or lower denture	$175 per denture
Endosteal Implants	Not a covered service
Orthodontics	Plan pays up to a maximum of $1,000 paid 25% initially, remaining 75% paid in equal monthly payments over the term of the Treatment Plan, not to exceed thirty-six (36) months

*Services must be obtained by an HMSA HMO dental network provider.
*12 month waiting period for new members for bridges, dentures, and crowns.
For a complete list of services and copayments please refer to the HMSA L95 Guide to Benefits as service limits and waiting periods for service may apply to certain procedures.

HMSA PPP Dental D90

Benefit Highlights	HMSA In & Out-of-Network Coverage
Calendar year Maximum	$2,000
Calendar Year Rollover	Accumulate up to $1,500
Deductible (Does not apply to Preventative Care and Orthodontics)	$25 per calendar year per member
Preventive Care	
Exams	$0
Cleaning	$0
Topical Fluoride	$0
X-Rays	$0
Routine Care	
X-rays - Periapical	30%
Fillings	30%
Sealants on permanent molars	30%
Space Maintainers	30%
Endodontics	30%
Periodontics	30%
Major Care	
Waiting Periods – New Members	12 month for Bridges, Dentures & Crowns
Crowns, Bridges	50%
Dentures	50%
Partial upper or lower denture	50%
Complete upper or lower denture	50%
Endosteal Implants	50%
Orthodontics	Plan pays up to a maximum of $1,500 paid 25% initially, remaining 75% paid in equal monthly payments over the term of the Treatment Plan, not to exceed thirty-six (36) months

*Benefits provided by a participating provider at a negotiated fee schedule.

- Out-of-state benefits available thru the DenteMax network (www.dentemax.com)
- Rollover amount is up to $600 per year if at least one dental service is received and benefits paid in the prior year do not exceed $800.
- Enhanced Dental Benefits
    - Members diagnosed with diabetes, coronary artery disease, oral cancer, and women who are pregnant may be eligible for additional services under the Enhanced Dental Benefits program. For more information visit www.hmsa.com/oralhealth

For a complete list of services please refer to the HMSA D90 Guide to Benefits as service limits and waiting periods for service may apply to certain procedures.

Dental Cost

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

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

	TOTAL MONTHLY	EMPLOYER PREMIUM		EMPLOYEE PREMIUM	
	PREMIUM	Bi-weekly	Weekly	Bi-weekly	Weekly
DENTAL					
L95 Prepaid Plan					
EE Only	$36.90	$17.03	$8.52	$0.00	$0.00
EE + One Dependent	$73.80	$25.55	$12.77	$8.52	$4.26
EE + Family	$110.70	$34.06	$17.03	$17.03	$8.52
D90 Preferred Provider Plan (PPO)					
EE Only	$36.90	$17.03	$8.52	$0.00	$0.00
EE + One Dependent	$73.80	$25.55	$12.77	$8.52	$4.26
EE + Family	$110.70	$34.06	$17.03	$17.03	$8.52

Flexible Spending Accounts

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 below)*.

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. ***Does not apply to Dependent Care.***

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 Term 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	1x annual base salary to a max of $250,000 with a minimum of

	$50,000	$25,000
AD&D	Match Life coverage	Match Life coverage

Life and AD&D

- Benefit level is reduced by 65% at age 75 and by 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).

- 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 for Vol Life and a maximum of $250,000 for Vol AD&D
- 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	$0.097	$0.120
Ages 45-49	$0.502	$0.157	$0.180

Ages 50-54	$0.862	$0.262	$0.285
Ages 55-59	$1.410	$0.427	$0.525
Ages 60-64	$1.627	$0.757	$0.810
Ages 65-69	$2.692	$0.930	$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:
  - The amount will match your Voluntary Life amount
- Spouses:
  - You may elect to add AD&D if both employee AD&D and Spouse Life are elected
    - AD&D will match the elected Spouse Voluntary Life amount
- Children:
  - You may elect to add AD&D if both employee AD&D and Child Life are elected
  - AD&D will match the elected Child Voluntary Life amount

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.

Hawaii Temporary Disability Insurance (TDI)

- Benefit Amount: Once you have been disabled for 7 days TDI will begin to provide you with 58% of your weekly salary up to a weekly maximum benefit of $570 – effective 1/1/16.
- Benefit Period: your TDI benefits may continue for up to 26 weeks if you continue to be disabled.

Supplemental Short Term Disability – Full Time Employees ONLY

- 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 after 13 days of an illness/injury
- Benefits will be offset by any Hawaii TDI or any sick leave benefits.
- 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.

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 illness or off-the-job injury.
- Benefits begin after an elimination period of 180 days and will continue until your social security normal retirement age, or until you no longer qualify for benefits, which ever occurs first.
    - 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.

Life Assistance Program

Personal problems can affect the lives of employees both at home and at work. When life's events become challenging, AURA employees have access to our Employee Assistance Program (EAP). The EAP is offered to all employees and immediate family members of AURA through the Life Assistance Plan – Cigna Behavioral Health. It is a completely Free and Confidential counseling program. The program provides up to three telephonic or face-to-face sessions per incident per calendar year. The EAP can assist with issues such as:

- Marriage, relationship and family
- Alcohol and drug dependency
- Stress and anxiety
- Depression
- Grief and loss
    - To access your benefits, you can contact our EAP toll free at
        - **1-800-538-3543**
    - Or you can visit the EAP website at **www.cignabehavioral.com/CGI**

You can access helpful information and powerful emotional health and work-life tools online:

- Search for a CIGNA Behavioral counselor, child, and eldercare directories
- Ask a CIGNA Behavioral expert an emotional health questions
- Access online seminars and self-help programs for stress, depression, insomnia, anxiety, substance abuse, etc.
- Find helpful tips, tools, and articles

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

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 bi weekly at the close of the pay period in which they are earned. The maximum amount that may be	Maximum contingent upon IRS regulations.* Employees may contribute the IRS determined maximum. An additional catch-up contribution is allowed for those 50 and older.

	contributed to this plan is $50,000.	($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 Center Director's will publish a Holiday calendar with the designated holidays in the US. Regular part-time employees receive the same holidays, as do regular full-time employees and 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 100% of tuition cost for grades of A or B and 50% for a grade of C.

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. **Error! No text of specified style in document.** and **Error! No text of specified style in document.** both have in-network providers.

How do I find an In-Network Provider?

- Check the back of your ID card for the Member Services number and call the carrier to see if your provider is contracted
- Visit the carrier's website and search their Provider Directory (refer to the last page of this Guide for contact information)

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 **Error! No text of specified style in document.** 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

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.

CHIPRA

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 you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS-NOW** or go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the 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).**

You should contact your state for further information on eligibility—

- Arizona: **www.azahcccs.gov/applicants**
  - Outside of Maricopa County: **1-877-764-5437**
  - Maricopa County: **1-602-417-5437**
- Arizona, Colorado, New Mexico

To see other states that have premium assistance, you may access this information at **www.dol.gov/ebsa/chipmodelnotice.doc**. To view additional states that have added premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

- U.S. Department of Health and Human Services—Centers for Medicare & Medicaid Services at **www.cms.hhs.gov** or **1-877-267-2323** Menu Option 4, Extension 61565
- U.S. Department of Labor—Employee Benefits Security Administration at **www.dol.gov/ebsa** or **1-866-444-EBSA (3272)**

OMB Control Number 1210-0137 (expires 10/31/16)

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Contact Information

Kaiser Medical/Vision	(800) 966-5955	www.kaiserpermante.org
HMSA Medical/Vision	(800) 766-4672	www.hmsa.com
COMPCARE Medical/Vision	(800) 678-9133 Option #3	
HMSA Dental	(800) 792-4672	www.hmsa.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	Shauna Cordero HR Generalist	(808) 974-2539 scordero@gemini.edu
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 efforts 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