Chile Benefits Guide

January 1

2019

TABLE OF CONTENTS

Introduction

AURA is committed to a comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work life balance.

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 active part-time and full-time employees regularly scheduled to work 20 or more hours per week. Employees may elect coverage for themselves, their legal spouse or domestic partner/civil union, and/or their dependent child(ren) who are under the age of 26 for Medical, Dental, Vision and Worksite Insurance. Domestic Partners are not eligible for Voluntary Life/AD&D.

For complete legal spouse or domestic partner/civil union and dependent children eligibility qualifications please refer to each carriers' Certificate of Coverage.

Dependent Social Security Numbers

Employers are required by Medicare legislation to collect Social Security Numbers for your enrolled dependents. When enrolling or renewing your medical coverage, please have this information with you for your spouse and eligible children. Please submit Social Security Numbers for newborns once they are issued.

When can I enroll for coverage?

- Initial eligibility – Date of hire
- Open Enrollment
- Qualifying Event (see "What is a Qualifying Event" on page 4)

You must submit an enrollment form in order to enroll, make changes, or waive 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 waive coverage. Open Enrollment is usually held each November with an effective date of January 1st. Our benefit plan year runs January 1, 2019 - December 31, 2019.

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

Open Enrollment elections should be completed online in UltiPro. ***If an employee fails to complete and submit online elections by the close of Open Enrollment, the employee's current coverage, with the exception of Flexible Spending Account elections, will continue with no change until the next Open Enrollment period.***

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
- Dependent child attainment of age 26

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

What's New

Effective 1/1/2019, the Cigna Short Term Disability benefit will begin on the 14th day of disability.

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 Base Plan 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 the Basic Term Life/AD&D, Short and Long Term Disability. Employees are responsible for the full cost of voluntary benefits – Vision and Voluntary Term Life/AD&D. Benefits premiums are paid through payroll deductions.

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 are binding and cannot be changed 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 MetLife Worldwide Benefits to provide Medical Plan Benefits. 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.

Medical Benefit Highlights

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		
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 / Skilled Nursing Facility / Inpatient Physical Rehab 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 month		
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 experts review the patient's medical records, provide a customized report, confirming the diagnosis and recommending a personalized treatment plan based on the latest medical research		

For rate information, refer to the Rate Sheet for your location.

Global Emergency Assistance

In addition to global medical benefits, MetLife Worldwide 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: metlifeexpat

Flexible Spending Accounts

Only employees that have reportable income in the U.S. are eligible to participate. Third country nationals without taxable income are not 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 costs (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 below 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.

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**

How an FSA works

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, 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. Please refer to IRS Publication 502 for a full list of qualified expenses, for example deductibles, copays, braces, eyeglasses, etc.

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. A child is a son, daughter, stepchild or foster child under the age of 27. You can contribute any amount up to a maximum of $2,700 for 2019.

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 Flexible Spending Account (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 Flexible Spending Account.

Every dollar reimbursed through your Dependent Care Flexible Spending Account 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.

FSA Elections

You must make your elections prior to the beginning of the plan year and/or your effective date. The Flexible Spending Account plan year is January 1, 2019 through December 31, 2019. Eligible expenses must be incurred during this period to be eligible for reimbursement. Incurred refers to the date the service is provided, regardless of when you are billed or when you pay for it. You may deposit:

- **Healthcare - maximum $2,700**
- **Limited Purpose – maximum $2,700**
- **Dependent Care - maximum $5,000**
    - If you file separate personal income tax returns, the annual contribution amount is limited to $2,500 each for both you and your spouse.

- If you file a joint income tax return and your spouse also contributes to a Dependent Care Flexible Spending Account through his or her employer, your family combined limit is $5,000.
- If your spouse is disabled or a full-time student, special limits apply. Limits are defined in the IRS Publication 503.
- If you and your spouse earn less than $5,000 combined, the maximum is limited to you and your spouse's combined earnings

Your elections for the plan year cannot be changed at will. Election changes are allowed only in the event of a status change as defined by the IRS. The change must be consistent with the status change per IRS rules. You must contact Human Resources within 30 days of the status change to make an election change. These include:

- Marriage or Divorce
- Birth or Adoption of a Child
- Death of an Eligible Dependent
- Certain Changes in Your Spouse's Employment Status
- Change of Care Giver (dependent care only)
- Child Turns 13 (dependent care only)

We encourage all employees to conservatively elect how much to deposit into their Healthcare and Dependent Care FSAs. The IRS requires that money in the accounts not used for eligible expenses incurred in the same plan year be forfeited for your daycare expenses. This is known as the "use it or lose it" rule. If you have a balance in your healthcare account at the end of the plan year any funds remaining in your account in excess of $500 will be forfeited.

AURA has chosen to allow you to rollover up to $500 of your previous year's balance of unused Healthcare FSA funds. Your balance will load after the plan finalization (run-out period 90 days plus plan finalization period 68 days) following of the plan year end. Going forward, until the rollover amount is depleted; up to $500 of unused funds will continue to roll from year to year as long as you are an active employee. You do not have to make a new election for the balance to roll from year to year.

Dental Benefits

AURA has contracted with MetLife Worldwide Benefits to provide Dental Plan Benefits. 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.

Dental Benefit Highlights

Benefit s	MetLife Worldwide Benefits
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

For rate information, refer to the Rate Sheet for your location.

Vision Benefits

AURA has contracted with MetLife Worldwide Benefits to provide Vision Plan Benefits. 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.

Vision Benefit Highlights

Benefits	MetLife Worldwide Benefits
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

For rate information, refer to the Rate Sheet for your location.

Basic Term Life and AD&D Benefits

AURA has contracted with Cigna to provide Basic Term 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

- 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
- Conversion and Portability Options
- Waiver of Premium
- Travel Assistance

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

Voluntary Term Life Benefits

Eligible employees are 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 guarantee issue up to specified limits. All elections above

the guarantee 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 one increment ($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 Term Life Cost

Monthly 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

- 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	$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 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.

Short Term Disability

AURA provides full-time employees with short- term disability income benefits; in the event you become disabled from a non-work related injury or medical condition that leaves you unable to work for a short period of time. Disability benefits become a valuable source of income when you are unable to work. This benefit is designed to replace a portion of your paycheck.

Short Term Disability	
Income Replacement	60% of weekly base salary
Weekly Maximum	$1,385
When Benefits Begin	14th day of disability
Maximum Benefit Period	26 weeks
Benefits Tax Treatment	Taxable

Long Term Disability

AURA provides each full-time employee with long- term disability insurance to cover loss of income should you become unable to work as a result of illness or injury for an extended period of time. Employees are eligible for Long Term Disability after 1 year of continuous active employment. Long Term Disability coverage insures a portion of your paycheck and helps you pay for expenses such as your mortgage payment, utility bills, groceries, etc.

Long Term Disability	
Income Replacement	60% of monthly base salary
Monthly Maximum	$6,000
When Benefits Begin	181st day of disability
Maximum Benefit Period	SSNRA
Cost of Living Adjustment (COLA)	3%
Retirement Savings	10% calculated on base salary
Benefits Tax Treatment	Taxable

Pre-Existing Condition: Limitation is applicable to this coverage for new enrollees. Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures) or for which a reasonable person would have consulted a physician during the 3 months just prior to the most recent effective date of insurance.

Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

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 for immediate participation in the 401(a) retirement plan upon date of hire. Non Regular Full-time or Part-time employees become eligible after completing 1,000 hours in a plan year.

The 401(a) Plan is funded entirely by employer contributions. AURA will contribute on a biweekly basis an amount equal to 10% of your eligible wages for the pay period. Employees are immediately vested at 100%. Upon completion of employment, you may have several options for distribution.

Fidelity Investments is the sole provider for the Plan. Eligible employee will be automatically enrolled in the program in the default Vanguard Target Date Funds Investor Shares. Once enrolled, employees may change investment selections from the funds offered within the plan and reallocate among the funds according to the terms of the Plan.

For more information, regarding provisions review the enrollment information at https://netbenefits.com/aura

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 $19,000 per year (2019 IRS limit). Certain "catch-up" provisions allow those over 50 years of age who meet certain eligibility qualifications to set aside an additional $6,000 (2018 IRS limit). 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.

Fidelity Investments is the exclusive retirement plan provider and record keeper for the AURA Retirement Plans. A tiered investment lineup offers a streamlined menu of investment options.

Information regarding the plan can be found at https://netbenefits.com/aura

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

Paid Time Off

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		

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. Temporary and part-time employees who work at least 20 hours per week receive proportionate sick leave credit.

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 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 Human Resources Office.

Health Plan Notices

Federal law requires health plans to provide a variety of notices to participating employees concerning their rights. Included in this packet are some of the required notices relating to your group health plan.

Plan Administrator Contact Information

If you have questions regarding any of the health plan notices that are being provided, please contact the plan administrator listed below:

Plan Administrator Contact – Association of Universities for Research in Astronomy, Inc. (AURA)

Street Address – 950 N. Cherry Ave.

City, State, Zip – Tucson, AZ 85719

Phone – (520) 318-8000

Summary of Material Reduction in Covered Services or Benefits / Summary of Material Modification

Short Term Disability	
Current Benefit Begins: Later of 50% of accumulated sick leave or 13 days of disability	Effective 1/1/2019 New Benefits Begin: 14th day of disability

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.

FMLA

Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page.

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

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.

HIPAA Special Enrollment Notice

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

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

To request special enrollment or obtain more information, contact your plan administrator

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.

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.

Newborns' & Mothers' 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).

Rescissions

The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Women's Health & Cancer Rights

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact your plan administrator for more information.

Glossary

Glossary of Terms

The following are terms commonly used when discussing benefits and insurance. This glossary contains terms used under our medical plan. These terms and definitions are intended to be educational and assist you in understanding how your medical plan works. For additional plan information, refer to your Summary of Benefits and Coverage (SBC).

Allowed Amount

Maximum amount on which payment is based for covered medical services. This may be called "eligible expense," "payment allowance" or "negotiated rate". If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When an out-of-network provider bills you for the difference between the Cigna's allowed amount and the provider's charge. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. For example, if the medical plan's allowed amount for a medical service is $100 and you've met your deductible, your co-insurance payment is 30%, then you would pay $30. The medical plan pays the rest of the allowed amount.

Copayment "Copays"

Copays are a fixed amount, which you pay at time of service. Copays are most common for prescription drugs, office, urgent care and emergency room visits. In some cases you may be responsible for paying a co-pay as well as percentage of the remaining charges.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. For example, if your individual deductible is $2,500; your plan will not pay anything for certain medical services until you have paid $2,500. A plan may also have separate deductibles that apply to specific services. The deductible may not apply to all services i.e. services that are covered by copay.

Explanation of Benefits

Your health plan sends you a record called an "Explanation of Benefits," or EOB that explains how much you owe. The EOB also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other healthcare professional is allowed to charge a member (called the "allowed amount").

In-Network Provider

An In-Network provider is a provider who has a service contract with your health insurance company or health plan to provide services to you at a discount.

Medically Necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Out-of-Network Provider

An Out-of-Network provider is a provider who doesn't have a service contract with your health insurance company or health plan to provide services to you. You'll pay more to see an Out-of-Network provider.

Out-of-Pocket Maximum

The most you pay during a period specified in the policy or certificate of coverage before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Preauthorization

A determination by a health insurance carrier or a health plan that a medical service, treatment plan, prescription drug, prosthetic device durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification

Prescription Drug Coverage

Coverage that helps pay for prescription drugs and medications covered under the health insurance carrier's formulary. A formulary is the list of FDA approved drugs covered under the medical plan. Each drug is classified into a tier and each tier determines the co-payment you will pay for the drug. Drug formularies typically have three or four tiers.

Primary Care Physician

A physician including a Medical Doctor, Doctors of Osteopathic Medicine, Internists, Family Practitioner, General Practitioner, OB/GYN and Pediatrician who directly provides or coordinates a range of medical services for a patient.

Specialist

A physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care

Care for an illness or injury serious enough that a reasonable person would seek care right away, but not as severe as to require emergency room care.

Contacts

Contact Information

Carrier	Benefit	Phone	Website
MetLife Worldwide Benefits	Medical / Vision / Dental	US: +1-913-814-6142 Outside US: +1-302-661-8674	www.metlifeexpat.com
TASC	Flexible Spending Account	(800) 422-4661	www.tasconline.com
CIGNA Group Insurance	Life, AD&D, & Disability	(800) 901-7534	www.cignawillcenter.com (Will Prep)
Cigna Behavioral	Life Assistance Program	(877) 622-4327	www.cignabehavioral.com Login:
Fidelity Investments	Financial & Retirement Consultant	(800) 343-0860	www.fidelity.com
TIAA-CREF	Financial & Retirement Consultant	(800) 842-2776	www.tiaa-cref.org
AURA Human Resources		benefits@aura-astronomy.org or contact your local HR Representative	

This benefit guide provides an overview of health and welfare benefits of AURA. This guide overview does not provide comprehensive plan details, for such please refer to the plan documents, including without limitation, policies, certificates of coverage, coverage booklets, and/or contracts for complete coverage details. Copies of such documents may be obtained upon request to AURA's Human Resources department. If any statement conflicts with the plan documents, the plan documents govern. This guide is not a contract, nor does it operate to create any legally enforceable obligations on the part of AURA, its agents or its employees.

Notes