Hawaii Benefits Guide

January 1

2019

TABLE OF CONTENTS

Introduction 3
Benefits Eligibility 3
What's New 4
Paying for Benefits 4
Medical Benefits 5
Health Reimbursement Account 8
Flexible Spending Accounts 9
Dental Benefits 11
Basic Term Life and AD&D Benefits 12
Voluntary Term Life Benefits 12
Voluntary Term Life Cost 12
Voluntary AD&D Benefits 13
Voluntary AD&D Cost 13
Disability Benefits 13
Life Assistance Program 14
Worksite Benefits 15
401(a) Money Purchase Pension Plan 16
403(b) Tax Sheltered Annuity 16
Paid Time Off 17
Tuition Reimbursement 18
Health Plan Notices 19
Medicare Part D Notice 25
Health Insurance Marketplace Coverage 28
Glossary 30
Contacts 32

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, 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/domestic partner 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 Term Disability and Long Term Disability. Employees are responsible for the full cost of voluntary benefits - Vision, Voluntary Term Life/AD&D, Accidental, Critical Illness and Hospital Indemnity benefit plans as well as the Pet Healthcare Discount Program. 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 HMSA and Kaiser to provide Medical Plan benefits. Both HMSA and Kaiser offer 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.

HMSA Medical Highlights

HMSA HMO

Benefits	In-Network ONLY
Deductible	$350 / $1,050
Out-of-Pocket Maximum Individual/ Family	$3,000 / $9,000 (Medical) $3,600 / $4,200 (Pharmacy)
Office Visit Copay	$20 copay
Preventive Care	No charge
Emergency Room	20% coinsurance after deductible
Acupuncture / Massage Therapy	$20 copay (A maximum number of visits per calendar year may apply)
Diagnostic Lab Doctor's Office or Clinic / Hospital	20% coinsurance / 20% coinsurance after deductible
Diagnostic X-Ray	20% coinsurance after deductible
Diagnostic Imaging (MRI / PET / CAT)	20% coinsurance after deductible
Inpatient / Outpatient Hospital	20% coinsurance after deductible
Prescription Drugs	
Retail Copay	$7 generic; $30 preferred brand; $30 other brand + $45 cost share copay; $100 preferred specialty; $200 other specialty brand
Mail Order	$11 generic; $65 preferred brand; $65 other brand + $135 cost share copay; 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 through COMPREHENSIVE CARE (American Specialty Health) questions can be directed to (800) 678-9133; Option #3

Vision – HMSA HMO Benefits

Benefit	In-Network	In-Network
	Adult	Child
Eye Exam Once per calendar year	$20 copay	$20 copay
Lenses (Single or Multifocal) Once per calendar year	$10 copay	$10 copay
Frames (Designated Group) One every 24 months	$15 copay	$15 copay
Contacts	$45 Exam Fitting Allowance; $25 copay; $130 Allowance	50% of eligible charge

HMSA PPP

Benefits	In-Network	Out-of-Network
Deductible	$350 / $1,050	
Out-of-Pocket Maximum Individual/ Family	$3,000 / $9,000 (Medical) $3,600 / $4,200 (Pharmacy)	
Office Visit Copay	$17 copay after deductible	
Preventive Care	No Charge	
Emergency Room	20% coinsurance after deductible	
Acupuncture / Massage Therapy	$20 copay (A maximum number of visits per calendar year may apply)	
Diagnostic Lab Doctor's Office or Clinic / Hospital	0% coinsurance after deductible / 20% coinsurance after deductible	
Diagnostic X-Ray	20% coinsurance after deductible	
Diagnostic Imaging (MRI / PET / CAT)	20% coinsurance after deductible	
Inpatient / Outpatient Hospital	20% coinsurance after deductible	
Prescription Drugs		
Retail Copay	$7 generic; $30 preferred brand; $30 other brand + $45 cost share copay; $100 preferred specialty; $200 other specialty brand	
Mail Order	$11 generic; $65 preferred brand; $65 other brand + $135 cost share copay; Specialty not offered	

Vision – HMSA PPP Benefits

Benefits	In-Network	In-Network
	Adult	Child
Eye Exam Once per calendar year	$10 copay	$10 copay
Lenses (Single or Multifocal) Once per calendar year	$10 copay	$10 copay
Frames (Designated Group) One every 24 months	$15 copay	$15 copay
Contacts	$45 Exam Fitting Allowance; $25 copay; $130 Allowance	50% of eligible charge

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

Kaiser Medical Highlights

Kaiser HMO

Benefits	Kaiser Facility
Deductible	N/A
Coinsurance	10%
Out-of-Pocket Maximum Individual/ Family	$2,500 / $7,500 Includes coinsurance and copays (Medical & Pharmacy)
Office Visit Copay	$20 copay
Preventive Care	No charge
Urgent Care	$20 copay
Emergency Room	$100 copay
Chiropractic Care	$20 copay
Diagnostic Lab (Basic / Specialty)	$10 per day / 20% coinsurance
Diagnostic X-Ray (Basic / Specialty)	$10 per day / 20% coinsurance
Diagnostic Imaging (MRI / PET / CAT)	20% coinsurance
Inpatient / 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.

Kaiser HMO Vision/Alternative Medicine/Active & Fit

Benefits	In-Network
Optical 150 (Vision)	All costs greater than a $150 allowance once every calendar year for glasses OR contact lenses
Active & Fit	$200 Gym / $10 Home fitness, per Calendar Year

Kaiser Added Choice

Benefits	In-Network	Out-of-Network
Deductible (Calendar)	Non-Embedded	
Individual / Family	None	$100 / $300
Coinsurance	20%	
Out-of-Pocket Maximum Individual / Family	$2,000 / $6,000 Includes coinsurance and copays (Medical & Pharmacy)	
Office Visit / Urgent Care Copay	$15 copay	20% coinsurance of MAC
Preventive Care	No charge	100% of MAC
Retail / Convenience Clinic	$15 copay	20% coinsurance of MAC
Urgent Care	$15 copay	20% coinsurance of MAC
Emergency Room	$75 copay	
Chiropractic Care	$15 copay (12 visit limit)	Not covered
Diagnostic Lab	10% coinsurance	20% coinsurance of MAC
Diagnostic X-Ray	10% coinsurance	20% coinsurance of MAC
Diagnostic Imaging (MRI / PET / CAT)	10% coinsurance	20% coinsurance of MAC
Inpatient Hospital	$75 copay per day	20% coinsurance of MAC
Outpatient Hospital	$15 copay	20% coinsurance of MAC
Prescription Drugs (In-Network)	Kaiser Provider	Contracted Provider
Deductible	None	
Retail Copay	$3 / $10 / $45 copay	20% not less than: $3 / $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: $6 / $10 / $45

- Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). It is the lesser of (1) the usual & customary charge; (2) the negotiated rate; or (3) the actual billed charges.
- Members are responsible for charges that exceed the MAC.

Kaiser Added Choice Vision / Alternative Medicine/Active & Fit

Benefits	In-Network	Out-of-Network
Optical 150 (Vision)	$150 allowance for glasses or contact lenses	$50 hardware allowance
Active & Fit	$200 Gym / $10 Home fitness, per Calendar Year	

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

Health Reimbursement Account

AURA offers Health Reimbursement Account (HRA) through TASC. This account was created for employees enrolled in one of the HMSA plans to help to pay for medical care expenses that are incurred by you, your spouse/domestic partner or your dependents and are not reimbursed by your health plan. These out-of-pocket expenses will apply towards the deductible only.

- The HRA will reimburse for the first $175 per member up to 3 members for In-Network medical deductible expenses only
- Members will be responsible for the second $175 per member up to 3 members of In-Network medical deductible expenses only

Please reference plan materials for additional information.

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**
- **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 contacted with HMSA to provide Dental Plan Benefits. There are two plans to choose from (referred to as the "HMO" and "PPP" Plans). The HMO is an **In-network ONLY** insurance service.

Dental Benefit Highlights

HMSA DHMO

Schedule L95	HMSA Dental Network Provider ONLY
Calendar year Maximum	None
Calendar Year Rollover	Not Applicable
Deductible	None
Preventive Care	
Exams Cleaning Topical Fluoride X-Rays	$0 $0 $0 $0
Routine Care	
X-rays - Periapical Fillings Sealants on permanent molars Space Maintainers Endodontics Periodontics	$0 $10 per tooth; $15 per tooth composite resin restoration $0; One per lifetime; age 16 and under $25 per procedure; Age 13 and under $15 per tooth for pulpotomy; $50 per tooth for root canal therapy $75 for gingivectomy for 4 or more contagious teeth $10 for 1 to 3 teeth contiguous teeth
Major Care Waiting Periods – New Members Crowns, Bridges Dentures Partial upper or lower denture Complete upper or lower denture Endosteal Implants	 12 month for Bridges, Dentures & Crowns $100 High noble metal $150 per denture $150 per denture $175 per denture 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	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; $75 per calendar year per family
Preventive Care	
Exams Cleaning Topical Fluoride X-Rays	$0 $0 $0 $0
Routine Care	
X-rays - Periapical Fillings Sealants on permanent molars Space Maintainers Endodontics / Periodontics	30% 30% 30% 30% 30%
Major Care Waiting Periods – New Members Crowns, Bridges Dentures Partial upper or lower denture Complete upper or lower denture Endosteal Implants	 12 month for Bridges, Dentures & Crowns 50% 50% 50% 50% 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.

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 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	Gemini & NOAO
Income Replacement	60% of weekly base salary
Weekly Maximum	$1,385 per week minus TDI Benefit
When Benefits Begin	14th day of disability
Maximum Benefit Period	26 weeks
Benefits Tax Treatment	Taxable

Hawaii TDI

Short Term Disability	
Eligibility	Employees working 20 or more hours a week and earns at least 8.67 times the prevailing minimum wage ($802 monthly)
Income Replacement	58% of weekly base salary
2018 Weekly Maximum	$620 (2019 max not yet published)
When Benefits Begin	8th day of disability
Maximum Benefit Period	26 weeks

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.

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 Life Assistance Program (LAP). The LAP is offered to all AURA employees and their household members through Cigna Behavioral. It is a completely Free and Confidential counseling program. The program provides telephonic or up to **three 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

Achieve work/life balance. Get extra support for handling life's demands. Call for advice or a referral to a service in the community on topics such as:

- Legal consultation
- Financial services
- Parenting
- Senior care
- Identity theft
- Child care
- Pet care

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

Worksite Benefits

Why Cigna?

- If you're sick or hurt, Cigna pays benefits directly to you not the hospital or your doctor to help with your expenses.
- While you focus on recovery, Cigna focuses on paying you quickly.
- It's your decision how to use the cash - use it to help pay for rent, childcare, or groceries.
- Plan participation can continue after termination of employment at the same payroll rate.
- Coverage is available for Dependent Children up to age 26.

Cigna Accident Injury Insurance

Additional financial protection for covered accidents

Cigna Accidental Injury insurance pays you (or whoever you designate) for treatments or injuries resulting from a covered accident. It can help you pay for expenses such as rehabilitation, transportation, childcare, travel or other out-of-pocket expenses. What you do with the money is all up to you. Coverage continues after your first covered accident and can help provide protection for future covered accidents.

Choose the coverage that works best for you and your family. Your monthly cost will depend on the level of coverage you choose.

Cigna Critical Illness Insurance

Additional financial protection

Cigna's Critical Illness insurance can help provide you and your family with the additional financial protection you may need for expenses associated with an unexpected covered critical illness – so you can focus on getting better. Cigna Critical Illness insurance pays you (or whoever you designate) a lump-sum benefit for diagnosis of a covered critical illness or specified event like a heart attack or stroke. It can help you pay for expenses such as travel, room and board, transportation, child care or treatment options not covered by traditional insurance. What you do with the money is up to you.

Choose the coverage that works best for you and your family. Your monthly cost will depend on the level of coverage you choose.

Cigna Hospital Care Insurance

How would you pay for a hospital stay? Even with medical coverage, out-of-pocket costs can add up. But with Cigna Hospital Care, you receive a check after a qualified hospitalization resulting from a covered injury or illness. You can use the money however you'd like.

For example, it can help you pay for expenses related to child care, travel, or other out-of-pocket expenses. There are no copays, deductibles, coinsurance, or network requirements. And benefits aren't reduced because you receive a payment from any other coverage you have, such as medical, accidental injury or critical insurance.

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

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

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		

Paid Time Off is not applicable to positions covered under the Davis Bacon and Related Acts.

NSO Center Exception: Vacation Accruals will be, "Capped" at 384-Hours effective July 1, 2018. If an employee has more than 384 unused vacation hours available on the pay date following July 1, 2018, the employee will not accrue vacation, until his/her balance falls below 384-Hours. Upon completion of employment, an NSO employee will be paid out for all unused vacation**.**

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

There are ten paid holidays each year, which include New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day and four holidays as designated by the Center Director. When a holiday occurs on a Saturday, the preceding Friday will be observed; when the holiday occurs on a Sunday, the following Monday is observed as the paid holiday.

Regular Part-time employees scheduled to work at least 20 hours per week 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.

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 **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)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2018. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
ALASKA – Medicaid	**NEW JERSEY – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
ARIZONA – CHIP	**NEW YORK – Medicaid**
Website: http://www.azahcccs.gov/applicants Maricopa County Phone: 602-417-5437 Outside Maricopa County Phone: 1-877-764-5437 (For effective dates of 9-1-2016 and after)	Website: http://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

ARKANSAS – Medicaid	NORTH CAROLINA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dma.ncdhhs.gov Phone: 919-855-4100
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**NORTH DAKOTA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
FLORIDA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
GEORGIA – Medicaid	**OREGON – Medicaid**
Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
INDIANA – Medicaid	**PENNSYLVANIA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
IOWA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-855-5563	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
KANSAS – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
KENTUCKY – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: http://chfs.ky.gov Phone: 1-800-635-2570	Website: http://dss.sd.gov Phone: 1-888-828-0059
LOUISANA – Medicaid	**TEXAS – Medicaid**
Website: http://dhh.louisiana.gov//index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
MAINE – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

MASSACHUSETTS – Medicaid and CHIP	VERMONT– Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
MINNESOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs/programs-and-servicrs/other-insurance.isp Phone: 1-800-657-3739	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
MISSOURI – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
MONTANA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
NEBRASKA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
NEVADA – Medicaid	**WYOMING – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2018 or for more information on special enrollment rights, you can contact either:

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

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

OMB Control Number 1210-0137 (expires 12//31/2019.)

Medicare Part D Notice

Important Notice from AURA
About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **AURA has determined that the prescription drug coverage offered by HMSA and Kaiser is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current AURA coverage will not be affected. Kaiser currently offers participants two plans, an HMO plan and a POS a 3 tier plan - $3 for tier 1 drugs, $10 for tier 2 drugs, and $45 for tier 3 drugs. HSMA currently offers participants two plans, an HMO plan and PPO plan with a 4 tier plan - $7 for Tier 1 drugs, $30 for Tier 2 drugs, $30 for Tier 3 drugs and $100 for tier 4 or Specialty drugs.

You can compare this coverage to the Medicare Prescription Drug plan offerings by reviewing a summary of the plans at http://www.medicare.gov/pdphome.asp. In addition, your current coverage pays for other health expenses in addition to prescription drugs. You will still be eligible to receive all of

your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current AURA coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

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

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

Contact the person listed below for further Kaiser at 800-966-5955 and HMSA at 800-776-4672. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through AURA changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage: Visit

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you

have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	1/1/2019
Name of Entity/Sender:	AURA
Contact – Position/Office:	Human Resources
Address:	950 N. Cherry Ave Tucson, AZ 85719
Phone Number:	520-318-8000

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

[1]An employer-sponsored health plan meets the “minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more

information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td colspan="2">1. Employer name
Association of Universities for Research in Astronomy, Inc. (AURA)</td><td colspan="2">2. Employer Identification Number (EIN)
86-0138043</td></tr>
<tr><td colspan="2">3. Employer address
950 N. Cherry Ave.</td><td colspan="2">4. Employer phone number
520-318-8000</td></tr>
<tr><td>5. City
Tucson</td><td colspan="2">6. State
AZ</td><td>7. ZIP code
85719</td></tr>
<tr><td colspan="4">8.Who can we contact about employee health coverage at this job?
Human Resources</td></tr>
<tr><td colspan="2">9. Phone number (if different from above)</td><td colspan="2">10. Email address
benefits@aura-astronomy.org</td></tr>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☑ All employees. Eligible employees are:
All regular full-time employees scheduled to work 30 or more hours per week.

☐ Some employees. Eligible employees are:

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:
Your legal spouse, dependent child(ren) who are under the age of 26 and dependent child(ren) age 26 or older who are or becomes disabled and dependent upon the employee

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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
HMSA	Medical / Vision	(800) 766-4672	www.hmsa.com
Kaiser	Medical / Vision	(800) 966-5955	www.kaiserpermante.org
CompCare	Medical / Vision	(800) 678-9133 Option #3	
TASC	Health Reimbursement Account	(800) 422-4661	www.tasconline.com
TASC	Flexible Spending Account	(800) 422-4661	www.tasconline.com
HMSA	Dental	(800) 766-4672	www.hmsa.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:
Cigna Worksite	Worksite Benefits	(800) 754-3207	www.cigna.com
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