



Chile

2021 Benefits Information Guide









Understanding your Options





Hello!

Welcome to your 2021 Benefits Plan Year. AURA is proud to offer a range of employee benefit plans to help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year. If you have any questions regarding your benefits, please contact Human Resources.

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Eligibility & Enrollment

Who can Enroll?

All active part-time and full-time employees regularly scheduled to work 20 or more hours per week, you are eligible to participate. Eligible employees may also choose to enroll family members, including a legal spouse/ registered domestic partner (as legally defined under state and local law) and unregistered domestic partner (hereinafter referred to as “registered and unregistered domestic partner”) and/or eligible children.

An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee’s state registered / unregistered domestic partner that does not meet the definition of the employee’s tax dependent under IRC Section 152.

Domestic Partners are not eligible for Voluntary Life/AD&D.

When Does Coverage Begin?

Regular, full-time and part-time employees: Coverage begins date of hire. 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 and Dental Insurance. Domestic Partners are not eligible for Voluntary Life/AD&D.

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2021 – December 31, 2021.

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information.

How do I Enroll?

Contact Human Resources

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change to Human Resources within 31 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's/registered and unregistered domestic partner's loss or gain of coverage through our organization or another employer.
- An employee (1) is expected to average at least 30 hours of service per week, (2) has a change in status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to \$0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov.

You may elect to "waive" medical and/or dental coverage if you have access to coverage through another plan. To waive coverage, log into UltiPro. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on January 1, 2022 or if a qualifying status change occurs.

Benefits Information on the Go

MetLife Worldwide – On the Go!

The MetLife Worldwide mobile app gives you a suite of tools to use on the go! Use this application to:

- Find a provider.
- Submit claims and check the status of claims.
- View ID cards.
- And more!



Search for MetLife Worldwide mobile app in the App Store or Google Play to get started!



Medical

Finding a Provider

Telehealth Services

With telehealth, you can connect with leading board-certified physicians for many non-emergency illnesses through the mobile app. By leveraging these virtual visits, you can receive consultation through call, text or video chat no matter where you are in the world.

Telehealth can be used for:



General Health Issues



Certain Specialty Services



Prescription

If your telehealth doctor prescribes you medication, MetLife Worldwide will ensure you are able to conveniently pick up your prescription in your local area. Through MetLife Worldwide, telehealth services are available at no charge for minor conditions or follow-up care.

Start your eVisit today!

- Online: www.AXATeleconsultation.com/MetLifeWorldwide.com.

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

- The MetLife Worldwide Benefits plans cover generic formulary, brand-name formulary, non-formulary brand, and specialty drugs.
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer.
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list.
- Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

For a current version of the prescription drug list(s), go to www.metlifeworldwide.com.

WHY PAY MORE?



There are a few ways you can save money when using the Prescription Drug Plan:



Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.



Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

Plan Highlights

MetLife Worldwide Benefits Medical Plan

	International	In-network U.S.	Out-of-network U.S.
Annual Calendar Year Deductible			
Individual		\$100	
Family		\$200	
Maximum Calendar Year Out-of-pocket ⁽¹⁾			
Individual		\$500	
Family		\$1,000	
Professional Services			
Primary Care Physician (PCP)		10% after deductible	
Specialist		10% after deductible	
Telehealth Visit		No charge	
Preventive Care Exam		No charge	
Diagnostic X-ray and Lab		10% after deductible	
Complex Diagnostics (MRI/CT Scan)		10% after deductible	
Chiropractic Services		10% after deductible	
Hospital Services			
Inpatient		10% after deductible	
Outpatient Surgery		10% after deductible	
Urgent Care		10% after deductible	
Emergency Room		10% after deductible	
Mental Health & Substance Abuse			
Inpatient		10% after deductible	
Outpatient		10% after deductible	
Retail Prescription Drugs (30-day supply)			
Tier 1			
Tier 2	10% after deductible	10% (Deductible Waived)	10% after deductible
Tier 3			
Mail Order Prescription Drugs (90-day supply)			
Tier 1			
Tier 2	Not Available	10% (Deductible Waived)	Not Available
Tier 3			

⁽¹⁾ Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

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

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.



Dental Plan

Your Dental PPO Plan

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by MetLife Worldwide Benefits.

Using the Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. To view a complete plan summary, please see Human Resources.

Plan Highlights

MetLife Worldwide Dental

	Worldwide
Calendar Year Deductible	
Per Person	\$25
Family Maximum	\$50
Calendar Year Maximum	\$2,000
Preventive	
Office Visit	
X-rays	0% deductible waived
Cleanings	
Basic Services	
Fillings	
Periodontics	20% after deductible
Endodontics	
Major Services	
Crowns	
Dentures	50% after deductible
Implants	
Orthodontia Services	
	50% after \$25 deductible for Child Only to age 19
Lifetime Maximum	\$1,500

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



Vision Plan

Vision coverage is offered by MetLife Worldwide Benefits and included as part of your medical plan. 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. To locate an in-network vision provider, visit www.metlifeworldwide.com.

MetLife Worldwide Benefits Vision (Included in Medical Benefit)

Plan Highlights

Exams	100% once every 12 months (Deductible waived)
Lenses, Frames Hardware	100% up to \$250 once every 12 months (Deductible waived)

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

TIPS

Five tips for having an excellent view

Don't underestimate your eyes! The following tips can help you keep your eyes healthy:

- Eat lots of dark green leaves and blackberries.
- Get regular eye exams.
- Allow your eyes to rest from the computer screen.
- Wear sunglasses to protect your eyes from bright light.
- Wear safety goggles whenever necessary.





Spending Accounts

Flexible Spending Accounts (FSA)

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.

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
 Health Care FSA	<ul style="list-style-type: none">• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance.• Maximum contribution for 2021 is \$2,750.
 Dependent Care FSA	<ul style="list-style-type: none">• Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves.• Maximum contribution for 2021 is \$5,000.

What are the benefits?

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

How do I use it?

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

A few rules you need to know:

- You may carryover up to \$550 from your 2021 Health FSA to the 2022 plan year
- Although the FSA plan year runs from January 1, 2021 through December 31, 2021, you have extra time after the end of the plan year March 31, 2022 to seek reimbursement for health care expenses incurred during the plan year January 1, 2021 through December 31, 2021. This reimbursement period is called an annual run-out period.

For more details about using an FSA, contact BASIC.



Life and Disability

Basic Life and AD&D

In the event of your passing, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Paid in full by AURA, the benefits outlined below are provided by Cigna:

- Basic Life Insurance of 1x annual earnings up to \$250,000 with a minimum of \$50,000 (Full-Time) and Basic Life Insurance of 1x annual earnings up to \$250,000 with a minimum of \$25,000 for Part-Time.
- Matching AD&D benefit.
- Please note, benefits reduce when you reach age 75.

IRS Regulation: Employees can receive employer paid life insurance up to \$50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of \$50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase on a payroll deduction basis through Cigna.

- **For employees:** Increments of \$10,000 up to the maximum of the lesser of 7x annual salary or \$500,000 with a guarantee issue benefit of \$100,000 if you enroll in the plan within 31 days of your initial eligibility.
- **For your spouse (up to age 70):** Increments of \$10,000 up to a \$150,000 maximum with a guarantee issue benefit of \$30,000 if you enroll in the plan within 31 days of your initial eligibility.
- **For your child(ren):** 14 days old up to 6 months of age, \$500; 6 months old up to age 26, \$10,000.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

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

Voluntary Life and AD&D Costs

For rates effective January 1, 2021 through December 31, 2021, employees should reference their location specific premium rate sheet for actual rates.



TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.**
- **To select or change your beneficiary, contact Human Resources.**

Short & Long Term Disability

Added protection

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans

Coverage Details

Short Term Disability (STD)

- Administered by Cigna, STD coverage provides a benefit equal to 60% of your earnings, up to \$1,385 per week for a period up to 26 weeks.
- The plan begins paying these benefits at the time of disability/after you have been absent from work for 14 consecutive days or exhaustion of sick leave, whichever is later.

Long Term Disability Coverage (LTD)

- If your disability extends beyond 180 days, the LTD coverage through Cigna can replace 60% of your earnings, up to maximum of \$6,000 per month.
- Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.

Tax considerations

Because disability coverage is an employer-paid benefit for Full-Time employees and is available for employees at no cost, any disability payments made to you will be taxable.

Please note: Consult your tax advisor for additional taxation information or advice.



Retirement Options

AURA offers three retirement savings plans for regular full-time and regular part-time benefits eligible staff:

- The 401(a) Plan for employer contributions (10% of base wages)
- The 403(b) Plan for employee contributions
 - Only employees that have reportable income in the US are eligible to participate. Third country nationals without taxable income in the US are not eligible to participate.
- The 457(b) Plan for employee contributions for highly compensated employees that max out the 403(b)
 - Only employees that have reportable income in the US are eligible to participate. Third country nationals without taxable income in the US are not eligible to participate.

Administered by Fidelity, the retirement savings plans allow you to plan for your future through employer contributions and by investing a portion of each paycheck. You become immediately eligible upon date of hire, for employer contributions of 10% of your base salary to the 401(a) and you may elect to have a percentage of your paycheck withheld and invested in your 403 (b) and/or 457(b) account, subject to federal law and plan guidelines. See Human Resources to confirm eligibility and enrollment dates.

Enrollment & Account Access

- You will be automatically enrolled in the 401(a) and 403(b) accounts, if eligible. To access your retirement plan account please visit <https://netbenefits.com/aura>.
- Check your account balances, view your contributions, change your investments and more by visiting <https://netbenefits.com/aura>. For login or password assistance, please contact Fidelity at 800.343.0860.

Additional Information

Contribution Limits for the 403(b) and 457(b): For 2021, the IRS annual contribution limits are \$19,500 for everyone under age 50 or \$25,500 for anyone that is age 50 or over prior to December 31, 2021. You must be making the maximum contribution to the 403(b) before you can contribute to the 457(b) account and your income must meet IRS Highly Compensated Employee Compensation Threshold (\$130,000 for 2021). If you have multiple employers during the year, these limits are combined for all types plans that you contribute to during the year. Restrictions may apply to these limits based on plan documents and annual testing requirements.

Contribution Changes: You can change your contributions and investment options through the Fidelity website. You may also stop your employee contribution entirely at any time. Requests to change or stop your contributions must be made through the Fidelity website <https://netbenefits.com/aura>.

Employer Contributions: AURA will contribute on a biweekly basis an amount equal to 10% of your eligible wages for the pay period into the 401(a) account. Employees are immediately vested at 100%.

Loans & Hardship Withdrawals: If allowed by the plan document, please see Human Resources for information and requirements for either option.

Rollover Contributions: If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your 403(b) plan. Please contact Fidelity for additional information.

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.

Marsh & McLennan Insurance Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.



Employee Assistance Program (EAP)

AURA understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you. The EAP program is available to you through MetLife Worldwide Benefits.

Program Component Coverage Details

Number of Sessions	6 face-to-face sessions per year per member per incident (MetLife Worldwide Benefits)
How to Access	Phone or face-to-face sessions
Topics May Include	Mental Health Support: <ul style="list-style-type: none">• Marital, relationship or family problems.• Bereavement or grief counseling.• Substance abuse and recovery.
Who Can Utilize	All employees, dependents of employees, and members of your household



Get in touch:
MetLife Worldwide Benefits

- By Phone: 1.416.382.3264 or in the US 844.670.3327 (toll free)
- Online: www.MetlifeWorldwide.com



Perks and More

Perks from Work

To round out your benefits package, we offer these additional perks to support both your personal and professional needs.

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	3.6923 hours
3-5	12	5.5385 hours
5 and over	16	7.3846 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.

Non-Exempt Employees		
Years of Service	Hours/Month	Bi-Weekly Accrual
1	8	3.6923 hours
2-3	13.5	6.2308 hours
3 and over	20	9.2308 hours

Holidays

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

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, limited to \$12,000 annual reimbursement. Approval must be obtained in advance of registering. Employees eligible for other reimbursement benefits such as the G.I. Bill shall be reimbursed for not more than the amount by which the tuition fee exceeds the benefits to which the employee is already entitled. If employment at AURA is voluntarily terminated, the employee must repay any tuition reimbursement benefits received within one (1) year of the termination date for course work. 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 Human Resources.

For more information regarding the above benefits please refer to AURA's absence policy [https://policies.aura-astronomy.org/B/B8\)%20B-VIII-Absences.pdf](https://policies.aura-astronomy.org/B/B8)%20B-VIII-Absences.pdf).

Costs, Directory, and Required Notices

Cost Breakdown



For rates effective January 1, 2021 – December 31, 2021, employees should reference their location specific premium rate sheet for actual rates.

Directory & Resources

Below, please find important contact information and resources for AURA.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
AURA Human Resources			benefits@aura-astronomy.org
Medical /Dental / Vision Coverage			
MetLife Worldwide Benefits	3894	1.913.814.6142 (U.S.) 1.302.661.8674 (Outside U.S.)	www.MetlifeWorldwide.com
Telemedicine			
MetLife Worldwide Benefits	3894	Mobile App	www.AXATeleconsultation.com/MetLifeWorldwide
Life, AD&D and Disability			
Cigna Life	FLX-963309		
Cigna AD&D	OK-964961		www.cigna.com
Cigna LTD	LK-962375	888.724.2262	www.cigna.mysecureadvantage.com (Will Prep)
Cigna STD	LK-750924		
Flexible Spending Accounts			
BASIC		800.372.3539	www.basiconline.com
Retirement Plan Adviser			
Fidelity		800.343.0860	www.fidelity.com
Retirement Plan Adviser			
TIAA-CREF		800.842.2776	www.tiaa-cref.org
EAP			
MetLife Worldwide Benefits	3894	416.382.3264 844.670.3327 (US)	www.MetlifeWorldwide.com
Benefits Broker / Benefit Questions			
Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC		520.722.7155	cnault@lovitt-touche.com
Claims Advocate- Catherine Nault			

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

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The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Medicare Part D notice

Important Notice about Your Prescription Drug Coverage and Medicare

Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 15 to December 7. 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 prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription 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).

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) 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.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage ⁽¹⁾
- Acquisition of a new spouse or dependent through marriage ⁽¹⁾, adoption ⁽¹⁾, placement for adoption ⁽¹⁾ or birth ⁽¹⁾
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) ⁽¹⁾
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
 - Change in legal marital status (e.g., marriage ⁽²⁾, divorce or legal separation)
 - Change in number of dependents (e.g., birth ⁽²⁾, adoption ⁽²⁾ or death)
 - Change in eligibility of a child
 - Change in your / your spouse's / your registered and unregistered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
 - A substantial change in your / your spouse's / your registered and unregistered domestic partner's benefits coverage
 - A relocation that impacts network access
 - Enrollment in state-based insurance Exchange
 - Medicare Part A or B enrollment
 - Qualified Medical Child Support Order or other judicial decree
 - A dependent's eligibility ceases resulting in a loss of coverage ⁽³⁾
 - Loss of other coverage ⁽²⁾
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

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

⁽¹⁾ Indicates that this event is also a qualified "Change in Status"

⁽²⁾ Indicates this event is also a HIPAA Special Enrollment Right

⁽³⁾ Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to any person covered under the plan who is a spouse, dependent child, or any other person eligible for COBRA continuation coverage under the plan.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

How is COBRA continuation coverage provided? (Continued)

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

AURA
Attention: D'Andrea Williams
Title: Human Resources Manager
950 N Cherry Avenue
Tucson, AZ 85719
520.318.8158

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness ⁽¹⁾; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. ⁽²⁾

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months ⁽³⁾, and if at least 50 employees are employed by the employer within 75 miles.

⁽¹⁾ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

⁽²⁾ The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"

⁽³⁾ Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TTY: (877) 889-5627 www.wagehour.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE: 01/01/2021

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part

by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.

- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
- Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.
- Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.
- Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- Maintain the privacy and security of your health information.
- Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

Association of Universities for Research in Astronomy (AURA)
Attention: D'Andrea Williams
Title: Human Resources Manager
950 N. Cherry Avenue
Tucson, AZ 85719
520.318.8158

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHIP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHIP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – 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	FLORIDA – Medicaid Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	GEORGIA – Medicaid Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	INDIANA – 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
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	NEVADA – Medicaid Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.nifamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration Centers for Medicare & Medicaid Services www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565
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Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Notice Regarding Availability of Health Insurance Exchange



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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 9.83% 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.

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 Department.

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.

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.

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.

3. Employer name Association of Universities for Research in Astronomy, Inc. (AURA)		4. Employer Identification Number (EIN) 86-0138043
5. Employer address 950 N. Cherry Ave.		6. Employer phone number 520.318.8000
7. City Tucson	8. State AZ	9. ZIP Code 85719
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above) Click here to enter text.		12. Email address benefits@aura-astronomy.org

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 hours or more per week

☐ Some employees. Eligible employees are:

- With respect to dependents:
- ☒ We do offer coverage. Eligible dependents are:

Your legal spouse / registered and unregistered domestic partner, and 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.

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