

# Benefits



Mainland

2021












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 full-time and part-time employees regularly scheduled to work 20 or more hours per week, 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?

Coverage begins the first of the month coinciding with or following 30 days of employment. Employees may elect coverage for themselves, their legal spouse or domestic partner/civil union, and/or their dependent child(ren) who are under the age of 26 for Medical, Dental, Vision and Worksite Insurance.

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

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

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## 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](http://www.cciio.cms.gov). You can also visit [www.coveredca.com](http://www.coveredca.com) to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, contact Human Resources. 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.





# Medical

## What are my options?

Use the chart below to compare medical plan options and determine which would be the best for you and your family.

	HDHP	PPO
	Cigna	Cigna
Required to select and use a Primary Care Physician (PCP)	No	No
Seeing a Specialist	No referral required	No referral required
Deductible Required	Yes Embedded: No	Yes, in most cases Embedded: Yes
Claims Process	PPO network providers will submit claims. You submit claims for other services.	PPO providers will submit claims. You submit claims for other services.
Compatible with your Health Savings Account (HSA)	Yes	No
Other Important Tips	<ul style="list-style-type: none"><li>• Although this plan has a higher deductible, it requires lower payroll deductions.</li><li>• The HSA account provides a tax-favored vehicle to help you manage your out-of-pocket expenses.</li><li>• Emergencies covered worldwide.</li></ul>	<ul style="list-style-type: none"><li>• You may choose in or out-of-network care, however in-network care provides you a higher level of benefit.</li><li>• Emergencies covered worldwide.</li><li>• Out-of-network providers will bill the balance to the member for amounts not covered by Cigna.</li></ul>

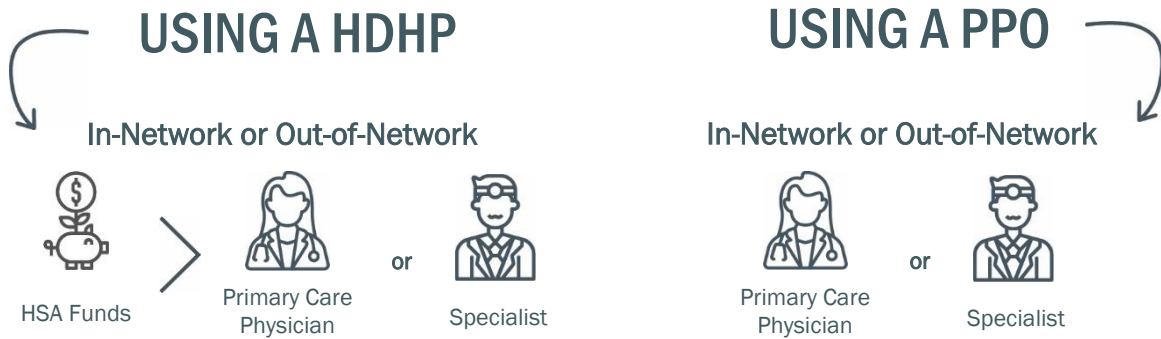
Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit [www.mycigna.com](http://www.mycigna.com).

## TIP

### Medical Services Covered in Full

The federal Health Care Reform law now requires insurance companies to cover preventive care services in full, saving you money and helping you maintain your health. Preventive services may include annual check-ups, well-baby and child visits and certain immunizations and screenings.

To confirm that your preventive care services are covered, refer to your plan documents.



### Cigna – On the Go!

The all-new myCigna Mobile App gives you a simple way to personalize, organize and access important health information – on the go. Features include:

- Health Care Professional Directory
- ID Cards
- Ability to view and search claims history
- Prescription Drug search
- View coverage details
- Save contact information for your doctor, pharmacies and other health care professionals or facilities
- And much more!



Search for Cigna's mobile app in the App Store or Google Play to get started!

# Finding a Provider

- **Open Access Plus**

- Cigna.com
- Click on “Find a Doctor, Dentist or Facility”
- Under “How are you Covered?” click on “Employer or School”
- Enter your location in the search box. Then select the type of service you would like to perform and follow the prompts to search for a provider
- Confirm your location under “I Live in” and click “Continue”
- Choose “Open Access Plus, OA plus, Choice Fund OA Plus” from the list of medical plans to see providers in the LocalPlus network

## Telehealth Services

With Cigna Telehealth Connection, you can connect with leading board-certified physicians for many non-emergency illnesses through the phone or video chat. By leveraging these virtual visits, you can avoid emergency rooms and urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

### Telehealth can be used for:



General Health Issues



Certain Specialty Services



Prescription

If your telehealth doctor prescribes you medication, Cigna will ensure you are able to conveniently pick up your prescription in your local area. Cigna provides access to Virtual Care services as part of your medical plan – MDLIVE. If your Virtual Care doctor prescribes you medication, Cigna will ensure you are able to conveniently pick up your prescription in your local area.

When you (and your enrolled family members) utilize these services, you will pay your Primary Care Physician (PCP) per visit copay if you are enrolled in the OAP Plan. If you are enrolled in the CHDP Plan, you will pay the full cost (average cost \$55) up to your deductible, payable at the time of service. Cost for Virtual Care visits are qualified expenses under both FSA and HSA regulations.

MDLIVE provides medical services and services related to mental health and substance abuse.

- Go to myCigna.com to search for a video Virtual Care specialist
- Call to make an appointment with your selected provider

Virtual Care visits with Cigna Behavioral Health and MDLive network providers cost the same as an in-office visit.

### Start your eVisit today!

#### MDLIVE

- By Phone: 888.726.3171
- Online: [www.mycigna.com](http://www.mycigna.com)
- Talk to a doctor or nurse 24/7 click Connect Now button
- You can also schedule a Doctor visit or Counseling visit by clicking the appropriate buttons

# 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 Cigna 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.mycigna.com](http://www.mycigna.com).

## WHY PAY MORE?

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



### Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy.



### 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

## Cigna CDHP/HDHP

	In-network	Out-of-network
<b>Annual Calendar Year Deductible</b>		
Individual	\$1,400	\$2,500
Family	\$2,800	\$5,000
<b>Maximum Calendar Year Out-of-pocket <sup>(1)</sup></b>		
Individual	\$1,400	\$5,000
Family	\$2,800	\$10,000
<b>Professional Services</b>		
Primary Care Physician (PCP)	0% after deductible	20% after deductible
Specialist	0% after deductible	20% after deductible
Telehealth Visit	0% after deductible	N/A
Preventive Care Exam	No charge	20% after deductible
Diagnostic X-ray and Lab	0% after deductible	20% after deductible
Complex Diagnostics (MRI/CT Scan)	0% after deductible	20% after deductible
Chiropractic Services	0% after deductible	20% after deductible
Eye Exam (1 per calendar year)	\$20 copay	Up to \$45 reimbursement
<b>Hospital Services</b>		
Inpatient	0% after deductible	20% after deductible
Outpatient Surgery	0% after deductible	20% after deductible
Urgent Care	0% after deductible	20% after deductible
Emergency Room	0% after deductible	
<b>Mental Health &amp; Substance Abuse</b>		
Inpatient	0% after deductible	20% after deductible
Outpatient	0% after deductible	20% after deductible
<b>Retail Prescription Drugs (30-day supply)</b>		
Tier 1	0% after deductible	50% after deductible
Tier 2	0% after deductible	50% after deductible
Tier 3	0% after deductible	50% after deductible
<b>Mail Order Prescription Drugs (90-day supply)</b>		
Tier 1	0% after deductible	Not covered
Tier 2	0% after deductible	Not covered
Tier 3	0% after deductible	Not covered

<sup>(1)</sup> 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.

## Plan Highlights

## Cigna OAP

	In-network	Out-of-network
<b>Annual Calendar Year Deductible</b>		
Individual	\$300	\$600
Family	\$600	\$1,200
<b>Maximum Calendar Year Out-of-pocket <sup>(1)</sup></b>		
Individual	\$1,300	\$2,600
Family	\$2,600	\$5,200
<b>Professional Services</b>		
Primary Care Physician (PCP)	\$20 copay	20% after deductible
Specialist	\$40 copay	20% after deductible
Telehealth Visit	\$20 copay	N/A
Preventive Care Exam	No charge	20% after deductible
Diagnostic X-ray and Lab	\$20 PCP / \$40 Specialist copay or 0% after deductible	20% after deductible
Complex Diagnostics (MRI/CT Scan)	0% after deductible	20% after deductible
Chiropractic Services	\$40 copay	20% after deductible
Eye Exam (1 per calendar year)	\$20 copay	Up to \$45 reimbursement
<b>Hospital Services</b>		
Inpatient	0% after deductible	20% after deductible
Outpatient Surgery	0% after deductible	20% after deductible
Urgent Care	\$35 copay	
Emergency Room	\$75 copay	
<b>Mental Health &amp; Substance Abuse</b>		
Inpatient	0% after deductible	20% after deductible
Outpatient	\$20 copay	20% after deductible
<b>Retail Prescription Drugs (30-day supply)</b>		
Tier 1	\$10 copay	50% after deductible
Tier 2	\$25 copay	50% after deductible
Tier 3	\$50 copay	50% after deductible
<b>Mail Order Prescription Drugs (90-day supply)</b>		
Tier 1	\$20 copay	Not covered
Tier 2	\$50 copay	Not covered
Tier 3	\$100 copay	Not covered

<sup>(1)</sup> 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.



# Supplemental Health

## Critical Illness Coverage

Critical Illness coverage offered on a voluntary basis through Cigna pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit.

### What can Critical Illness coverage pay for?

- Medical expenses, such as copays, deductibles or co-insurance
- Lost Income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to a specialist

### What are examples of covered illnesses or conditions?

- Cancer
- Heart Attack
- Stroke
- Kidney Failure
- Major Organ Failure

### Here's an example of how Critical Illness coverage can help support you

Denise is 45 years old and had a heart attack. She was out of work for a couple of months recovering and although she had disability insurance, it didn't cover all of her lost income and medical bills. Thankfully, Denise had a \$10,000 Critical Illness policy. She filed her claim and received her cash benefit so that she could pay her bills and medical expenses. With her Critical Illness policy, Denise had peace of mind and was able to focus on improving her health.

### 100% Employee-paid

If you elect the voluntary Critical Illness plan, 100% of the cost is deducted through payroll deductions. Monthly post-tax rates can be found in UltiPro.

### Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	\$5,000, \$10,000 or \$20,000 (All Guaranteed Issue)
Spouse	Up to 50% of Employee benefit election (Guaranteed Issue up to \$10,000)
Child(ren)	Children are automatically covered at 25% of employee

### Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits please see Human Resources.

# Hospital Protection

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital Insurance offered on a voluntary basis through Cigna pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

## How can Hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Child care
- Lodging expenses for a companion
- Lost income

## Here's an example of how Hospital Insurance can help support you

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5-day hospital stay. Through his primary medical insurance, Trevor owed a \$500 deductible and \$3,000 in co-insurance. With the help of his Hospital Insurance coverage, which paid a \$1,000 admission benefit plus \$150 for each additional day, he was only out of pocket \$1,900 instead of \$3,500.

### Out-of-Pocket Expenses

\$500 deductible
\$3,000 co-insurance
<b>Total: \$3,500</b>

### Hospital Indemnity Plan Benefits

\$1,000 admission benefit
\$150/day x 4 additional days = \$600
<b>Total benefits paid to Trevor: \$1,600</b>

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

## 100% Employee-paid

If you elect the voluntary Hospital Insurance plan, 100% of the cost is deducted through payroll deductions. Monthly post-tax rates are outlined below:

Election	Monthly Contribution
Employee Only	\$19.11
Employee + Spouse	\$40.71
Employee + Child(ren)	\$31.42
Family	\$53.01

## Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits please see Human Resources.



# Accident Insurance Plan

Accident Insurance offered on a voluntary basis through Cigna provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

## How can Accident Insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

## What are some common covered benefits?

- Emergency room visit
- Ambulance
- Doctor visits
- Hospital admission
- Surgery
- Medical equipment
- Outpatient therapy
- Diagnostic imaging

Covered Event/Injury	Benefit Amount
Ambulance (ground)	\$300
Emergency room care	\$150
Physician follow-up (\$75 x 2)	\$150
X-ray	\$50
Concussion	\$150
Broken tooth (repaired by crown)	\$300
<b>Total benefit paid by Kathy's Accident Plan</b>	<b>\$1,100</b>

## Here's an example of how Accident Insurance can help support you

Kathy's daughter, Molly, plays soccer. During a recent game, she collided with a player, was knocked unconscious and taken to the emergency room (ER) by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He ordered an x-ray scan to check for facial fractures due to swelling. Molly was released to her primary care physician for follow-up treatment and her dentist repaired her broken tooth with a crown. Thanks to Accident Insurance, Kathy will receive \$1,100 to help pay for Molly's expenses associated with her accident.

**Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.**

## 100% Employee-paid

If you elect the voluntary Accident Insurance plan, 100% of the cost is deducted through payroll deductions. Monthly post-tax rates are outlined below:

Election	Monthly Contribution
Employee Only	\$7.57
Employee + Spouse	\$13.29
Employee + Child(ren)	\$14.22
Family	\$19.35

## Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits please see Human Resources.

# Workplace Wellness



## Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. We care about your total well-being and encourage all employees to engage in our Wellness Program at no-cost.

## HealthCheck360

HealthCheck360 is a wellness company devoted to improving health and overall wellbeing. HealthCheck360 provides you with the tools, motivation, and support to assist you along your journey to a healthier you. You will receive a personalized, confidential report of your health status after your wellness screening. HealthCheck360 uses the same confidentiality standards as your doctor. From there, you will have access to health coaches who can help you learn more about your results and set personal goals. Keep an eye out for wellness challenges, recipes, webinars, and more to make focusing on your health fun and easy.

Create an account on your myHealthCheck360 mobile app or online at [www.myhealthcheck360.com](http://www.myhealthcheck360.com)

- Schedule Health Screenings
- Challenges
- Lifestyle Rewards
- Health results and survey
- FitBit/Garmin/Apple Watch and other Device Integration for each tracking
- Goal-setting tools
- Monthly Newsletter/Webinars
- Healthy recipes, meditation classes and home workouts
- Health Coaching support

### Create Your Account: **Mobile App**

- Download the myHealthCheck360 app
- Click **Create An Account** and enter your information
  - Your company code is **AURAA**
  - Your unique identifier is your **last 4 SSN**
- Agree to the terms and conditions and **click Sign Up**

### Create Your Account: **Desktop Computer**

- Log into your myHealthCheck360 account at [www.myhealthcheck360.com](http://www.myhealthcheck360.com)
- Click **Create A New Account** and enter your information
  - Your company code is **AURAA**
  - Your unique identifier is your **last 4 SSN**
- Agree to the terms and conditions and **click Sign Up**



## Incentives

AURA is continuing the Employee Wellness Program for all employees covered under the medical plans. Earn incentives for participating in the HealthCheck360 Preventive Screenings and other wellness activities.

Incentives are either; HSA contributions for those that are eligible to contribute to an HSA; or Premium reductions for those that are not eligible to contribute to an HSA.

### 2021 Maximum Incentives

1. Enrolled as Employee Only - \$700
2. Enrolled as Employee + One - \$1,000
3. Enrolled as Family - \$1,000

Only employees and spouses may receive incentives for participation in the wellness program.

Employees have multiple ways to earn incentives:

	Activity	Incentive
HealthCheck360	Participation (Complete the biometric screenings)	Employee - \$550 Spouse - \$350
Cigna Health Coaching Programs	Completions will be reported to AURA by Cigna	Employee - \$150 Spouse - \$75
Health Coaching	Completions will be reported to Healthcheck360 by WELCOAZ	Employee (3 session max) \$50 per session
Cigna Health Risk Assessment	Completions will be reported to AURA by Cigna	Employee - \$50 Spouse - \$25
Annual Medical Preventive Exams	Completions will be reported to AURA by Cigna	Employee - \$150 Spouse - \$75
Annual Dental Preventive Exam	Completions will be reported to AURA by Cigna	Employee - \$75 Spouse - \$50

AURA will issue incentives quarterly.



# Dental Plan

## Your Dental DHMO & PPO Plan

You and your eligible dependents will have the opportunity to enroll in a Dental Health Maintenance Organization (DHMO) plan offered by Cigna or a Dental Preferred Provider Organization (PPO) plan offered by Cigna. We encourage you to review the coverage details and select the option that best suits your needs.

## Using the Plan

If you decide to enroll in the Dental DHMO plan, you and your enrolled eligible dependents must first select a primary care dentist who participates in the Cigna network. To receive benefits in the Dental HMO plan, your dental care must either be provided by or referred to a specialist by your primary care dentist. If you receive services from any other dentist, you would be responsible for paying the entire dental bill yourself. **Please note: DHMO plan is not available in New Mexico.**

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

To view a complete plan summary, please see Human Resources.

### TIP

### Choose your Primary Care Dentist

It's important to carefully select a dental provider, and based on the plan you enroll in, the best choice for you may vary. To determine whether your dentist is in or out of your insurance network, go to [www.mycigna.com](http://www.mycigna.com) and search the provider network or call Cigna. Primary Care Dentist changes made after the first two days of the month will be effective the following month.

## Finding a Provider

### • Open Access Plus

- Cigna.com
- Click on "Find a Doctor, Dentist or Facility"
- Under "How are you Covered?" click on "Employer or School"
- Enter your location in the search box. Then select the type of service you would like to perform and follow the prompts to search for a provider
- Confirm your location under "I Live in" and click "Continue"
- Choose:
  - DHMO - Cigna Dental Care DHMO > Cigna Dental Care Access Plus
  - DPPO – Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)



Plan Highlights	Cigna Dental DHMO	Cigna Dental PPO	
	In-network (Access Plus)	In-network (Advantage)	Out-of-network
Calendar Year Deductible			
Per Person	None		\$50
Family Maximum	None		\$150
Calendar Year Maximum	None	\$2,000	\$1,500
Preventive			
Office Visit	\$0 copay		0% no deductible
X-rays	\$0 copay		0% no deductible
Cleanings	\$0 copay		0% no deductible
Basic Services			
Fillings	\$22	0% after deductible	20% after deductible
Major Services			
Crowns	\$470	40% after deductible	50% after deductible
Dentures	See Schedule	40% after deductible	50% after deductible
Implants	\$770	40% after deductible	50% after deductible
Orthodontia Services			
Procedures & Treatment	See Schedule	Covered at 50% no deductible	
Lifetime Maximum	See Schedule	\$1,500	\$1,000

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 EyeMed as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit [www.eyemed.com](http://www.eyemed.com).

## Plan Highlights

## EyeMed Vision PPO

	In-Network (Insight)	Out-of-Network
Exam – Every 12 months	\$10 copay	Up to \$40 Reimbursement
Lenses – Every 12 months		
Single	\$25 Copay	Up to \$30 Reimbursement
Bifocal	\$25 Copay	Up to \$50 Reimbursement
Trifocal	\$25 Copay	Up to \$70 Reimbursement
Frames – Every 12 months		
Frames	\$130 allowance, then 20% discount	Up to \$91 Reimbursement
Additional Pairs of Glasses	40% discount	N/A
Contacts – Every 12 months, in lieu of lenses		
Medically Necessary	Covered in full	Up to \$210 Reimbursement
Elective	\$110 allowance	Up to \$77 Reimbursement
LASIK	15% discount (retail) or 5% discount promotional	Provider Contracted Amount

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

## Health Savings Account (HSA)

### What is it?

By enrolling in the CDHP/HDHP plan, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

### What are the benefits?

Administered by HSA Bank, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return.
- Generally, HSA funds can grow on a tax-free basis, subject to state law.<sup>1</sup>
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no “Use it or Lose it” provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.
  - AURA contributes money into your Health Savings Account for you to help offset some of your out of pocket costs. These funds roll over year-after-year and are yours to keep regardless of your employment with AURA.

### How do I qualify for an HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified medical plan.
- You are not enrolled in non-qualified health insurance outside of AURA's CDHP/HDHP Medical Plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

Once the HSA is activated, you can manage and access your account at any time by visiting [www.hsabank.com](http://www.hsabank.com). If questions arise regarding account activation, contact HSA Bank or visit [www.hsabank.com](http://www.hsabank.com). Consult your tax advisor for taxation information or advice.

<sup>(1)</sup> Please consult your tax advisor for applicable tax laws in your state.

## A few rules you need to know:

- For 2021, the maximum contribution limit for employee and employer contributions in an employee's HSA account is \$3,600 if you are enrolled in the CDHP/HDHP for employee-only coverage, and \$7,200 for employees with dependent coverage.
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit [www.hsabank.com](http://www.hsabank.com).
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.
- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

### TIP

## How do I manage my HSA?

- The most convenient way to pay for qualified expenses is to utilize the debit card
- You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account
- It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS
- View the status of your claims and check your HSA balance at [www.hsabank.com](http://www.hsabank.com).

## WHAT TO KNOW ABOUT YOUR HEALTH SAVINGS ACCOUNT



You own your HSA



Your money rolls over year after year



You choose how much to contribute  
(max. amounts apply)



Paired with a high-deductible health plan






You receive a triple tax advantage



# Flexible Spending Accounts (FSA)

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"><li>• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance.</li><li>• Maximum contribution for 2021 is \$2,750.</li></ul>
 Dependent Care FSA	<ul style="list-style-type: none"><li>• 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.</li><li>• Maximum contribution for 2021 is \$5,000.</li></ul>
 Limited Purpose FSA	<ul style="list-style-type: none"><li>• Option for employees enrolled in a Health Savings Account (HSA) eligible plan.</li><li>• Use this FSA to reimburse for eligible preventive care, dental and vision expenses.</li><li>• Maximum contribution for 2021 is \$2,750.</li></ul>

## 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](http://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, 90 days, 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 for 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 for Full-time employees and Basic Life Insurance of 1x annual earnings up to \$250,000 with a minimum of \$25,000 for Part-time employees.
- 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 Life and AD&D 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 Cost

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
- The 457(b) Plan for employee contributions for highly compensated employees that max out the 403(b)

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.
- 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. Two EAP programs are available to you through Cigna and Optum.

Program Component	Coverage Details
Number of Sessions	3 face-to-face sessions per year per member per incident (Cigna Life Assistance Program) 3 face-to-face sessions per year per member per incident (Optum)
How to Access	Phone or face-to-face sessions
Topics May Include	Mental Health Support: <ul style="list-style-type: none"><li>• Marital, relationship or family problems.</li><li>• Bereavement or grief counseling.</li><li>• Substance abuse and recovery.</li></ul> Community Support: <ul style="list-style-type: none"><li>• Childcare and eldercare.</li><li>• Legal services and Identity theft.</li><li>• Financial support.</li><li>• Educational materials.</li></ul>
Who Can Utilize	All employees, dependents of employees, and members of your household



**Get in touch:**  
**Cigna Life Assistance Program**

- By Phone: 800.538.3543
- Online: [www.cignalap.com](http://www.cignalap.com)

**Optum Employee Assistance Program and WorkLife Services**

- By Phone: 866.248.4094
- Online: [www.liveandworkwell.com](http://www.liveandworkwell.com)
- Access code: AURA



# 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		

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

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

### Sick Leave

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.

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

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

Regular part-time employees scheduled to work at least 20 hours per week receive the same holidays, as do full-time employees. Part-time employees 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).

# Supplemental Services

## Pet Insurance and Pet Healthcare Discount Program

For many of us, our pets are just as special and loved as our family members. That's why it's important we protect their health too! Our Pet Insurance benefits, offered by Nationwide and our Pet Healthcare Discount Program offered by United Pet Care, covers dogs, cats, birds and some other exotic animals. Some of the covered benefits for your pet may include allergies, diabetes, cut or bite wounds, infections, heart failure, skin cancer, and more.

Check out the plans on Nationwide's website at [www.PetsVoluntaryBenefits.com](http://www.PetsVoluntaryBenefits.com) or contact them to discuss the best coverage for your animal. The employee will pay for coverage through Nationwide directly (not via paycheck deductions).

Check out the plans on United Pet Care's website at <http://www.unitedpetcare.com/aura> or contact them to discuss the best coverage for your animal. The employee will pay for coverage through paycheck deductions.

## Legal Services

When you need guidance on personal legal matters, LegalShield services can provide you with access to a network of qualified attorneys. Whether you prefer telephonic or in-office consultation, you may receive guidance on topics such as debt matters, family law, preparation of wills, real estate matters, trusts, and more. To get started, please visit <http://benefits.legalshield.com/aura>.

Coverage for business or employment related legal concerns may not be offered. To learn more or begin coverage, contact Human Resources.

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# 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	
<b>Enrollment &amp; Eligibility</b>			
AURA Human Resources			<a href="mailto:benefits@aura-astronomy.org">benefits@aura-astronomy.org</a>
<b>Medical / Dental / Telehealth Coverage</b>			
Cigna	3328775	866.494.2111	<a href="http://www.mycigna.com">www.mycigna.com</a>
MDLIVE		888.726.3171	
<b>Vision Coverage</b>			
EyeMed	1030842	866.939.3633	<a href="http://www.eyemed.com">www.eyemed.com</a>
<b>Life, AD&amp;D and Disability</b>			
Cigna Life	FLX-963309		
Cigna AD&D	OK-964961	888.724.2262	<a href="http://www.cigna.com">www.cigna.com</a>
Cigna LTD	LK-962375		<a href="http://www.cigna.mysecureadvantage.com">www.cigna.mysecureadvantage.com</a> (Will Prep)
Cigna STD	LK-750924		
<b>Worksite</b>			
Cigna Accident	AI960532c01		
Cigna Critical Illness	CI960529c01	800.754.3207	<a href="http://www.cigna.com">www.cigna.com</a>
Cigna Hospital Indemnity	HC960141c01		
<b>Health Savings Account</b>			
HSA Bank		800.357.6246	<a href="http://www.hsabank.com">www.hsabank.com</a>
<b>Flexible Spending Accounts</b>			
BASIC		800.372.3539	<a href="http://www.basiconline.com">www.basiconline.com</a>
<b>Retirement Plan Adviser</b>			
Fidelity		800.343.0860	<a href="http://www.fidelity.com">www.fidelity.com</a>
<b>Retirement Plan Adviser</b>			
<b>TIAA-CREF</b>		800.842.2776	<a href="http://www.tiaa-cref.org">www.tiaa-cref.org</a>
<b>EAP</b>			
Cigna Life Assistance Program		(800) 538-3543	<a href="http://www.cignalap.com">www.cignalap.com</a>
Optum EAP and WorkLife Services		(866) 248-4094	<a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a> Access code: AURA
<b>Pet Insurance</b>			
Nationwide		800.540.2016	<a href="http://www.petinsurance.com">www.petinsurance.com</a>
United Pet Care			<a href="http://www.unitedpetcare.com/aura">http://www.unitedpetcare.com/aura</a>
<b>Legal &amp; Identity Theft Protection</b>			
LegalShield		888.807.0407	<a href="http://www.benefits.legalshield.com/aura">www.benefits.legalshield.com/aura</a>
<b>Benefits Broker / Benefit Questions</b>			
Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC		520.722.7155	<a href="mailto:cnault@lovitt-touche.com">cnault@lovitt-touche.com</a>
Claims Advocate- Catherine Nault			

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## 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](http://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](http://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 <sup>(1)</sup>
- Acquisition of a new spouse or dependent through marriage <sup>(1)</sup>, adoption <sup>(1)</sup>, placement for adoption <sup>(1)</sup> or birth <sup>(1)</sup>
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) <sup>(1)</sup>
- 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 <sup>(2)</sup>, divorce or legal separation)
  - Change in number of dependents (e.g., birth <sup>(2)</sup>, adoption <sup>(2)</sup> 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 <sup>(3)</sup>
  - Loss of other coverage <sup>(2)</sup>
- 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.

<sup>(1)</sup> Indicates that this event is also a qualified "Change in Status"

<sup>(2)</sup> Indicates this event is also a HIPAA Special Enrollment Right

<sup>(3)</sup> 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](http://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](http://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](http://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

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

## 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 <sup>(1)</sup>; 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. <sup>(2)</sup>

### 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 <sup>(3)</sup>, and if at least 50 employees are employed by the employer within 75 miles.

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

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

<sup>(3)</sup> 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](http://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](http://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

## NOTICE REGARDING WELLNESS PROGRAM

AURA sponsors HealthCheck360, a voluntary wellness program available to health plan employees and spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for HDL, LDL, Triglycerides, Total Cholesterol, Glucose, GGT, Cotinine, Creatinine, Albumin, ALP, Total Protein, ALT, AST, GSP, Bilirubin, Globulin, and BUN. The blood test may also include TSH, PSA, CBC, A1c, and hs-CRP. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, health plan employees and spouses who choose to participate in the wellness program will receive an HSA incentive of \$550 for employee & \$350 spouse or a premium reduction. Although you are not required to complete the HRA or participate in the biometric screening, only health plan employees and spouses who do so will receive incentive.

Additional HSA incentives of up to \$150/individual and \$100/family may be available for health plan employees and spouses who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HealthCheck360 at 1-866-511-0360 or support@healthcheck360.com by 11/30/2020.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

## PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and AURA may use aggregate information it collects to design a program based on identified health risks in the workplace, HealthCheck360 will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) employees of HealthCheck360 in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources, or contact HealthCheck360 at 866-511-0360 or support@healthcheck360.com

# 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](http://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](http://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](http://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 –**

<b>ALABAMA – Medicaid</b>  Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	<b>COLORADO – Health First Colorado (Colorado's Medicaid Program) &amp; Child Health Plan Plus (CHIP+)</b>  Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHIP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHIP+ Customer Service: 1-800-359-1991/ State Relay 711
<b>ALASKA – Medicaid</b>  The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>	<b>FLORIDA – Medicaid</b>  Website: <a href="http://flmedicaidprecovery.com/hipp/">http://flmedicaidprecovery.com/hipp/</a> Phone: 1-877-357-3268
<b>ARKANSAS – Medicaid</b>  Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	<b>GEORGIA – Medicaid</b>  Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext 2131
<b>CALIFORNIA – Medicaid</b>  Website: <a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a> Phone: 1-800-541-5555	<b>INDIANA – Medicaid</b>  Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864
<b>IOWA – Medicaid and CHIP (Hawki)</b>  Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Hawki Phone: 1-800-257-8563	<b>MONTANA – Medicaid</b>  Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084
<b>KANSAS – Medicaid</b>  Website: <a href="http://www.kdheks.gov/hcf/default.htm">http://www.kdheks.gov/hcf/default.htm</a> Phone: 1-800-792-4884	<b>NEBRASKA – Medicaid</b>  Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
<b>KENTUCKY – Medicaid</b>  Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a> KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a> Phone: 1-877-524-4718 Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a>	<b>NEVADA – Medicaid</b>  Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900
<b>LOUISIANA – Medicaid</b>  Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	<b>NEW HAMPSHIRE – Medicaid</b>  Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
<b>MAINE – Medicaid</b>  Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a> Phone: 1-800-442-6003 TTY: Maine relay 711	<b>NEW JERSEY – Medicaid and CHIP</b>  Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.nifamilycare.org/index.html">http://www.nifamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
<b>MASSACHUSETTS – Medicaid and CHIP</b>  Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a> Phone: 1-800-862-4840	<b>NEW YORK – Medicaid</b>  Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
<b>MINNESOTA – Medicaid</b>  Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp</a> [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	<b>NORTH CAROLINA – Medicaid</b>  Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100
<b>MISSOURI – Medicaid</b>  Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005	<b>NORTH DAKOTA – Medicaid</b>  Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825

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

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](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

<sup>1</sup> 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 and part-time employees regularly scheduled to work 20 or more hours 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

## Notes

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