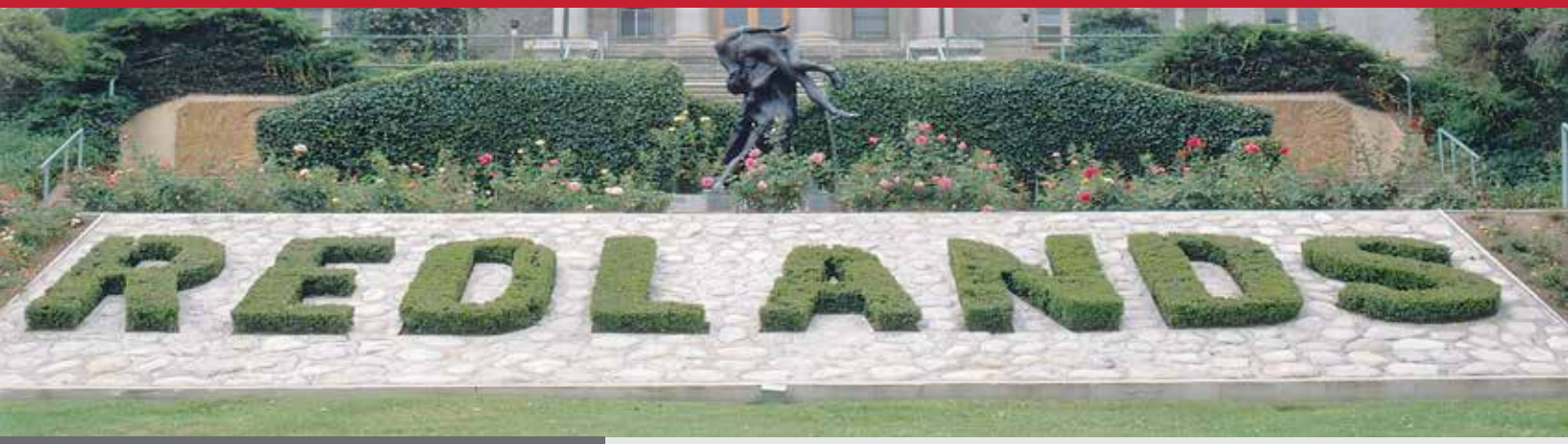
UNIVERSITY OF Redlands

2015-2016 Health Benefits

a Brief Summary Guide



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See page 20 for an Important Notice regarding your Medicare Part D Coverage.

UNIVERSITY OF Redlands

The University of Redlands recognizes that benefits are an important part of your total compensation. We have created a comprehensive, high quality, benefits package to meet the needs of you and your family. This brochure summarizes the options available to you and what your contributions will be for the duration of the policy year. The information in this booklet has been prepared for you to help make the enrollment process easier to understand and more efficient. You may also be eligible to participate in other University sponsored programs. Please contact Human Resources for details.

Whether this is your first annual enrollment or you've been through it many times, selecting your benefits can be challenging. As a healthcare consumer, it is very important that you educate yourself about the various health plans being offered. In making your elections, you should consider the benefits, ease of obtaining healthcare, costs, and how well the plan meets the needs of you and your family.

This brochure contains an overview of the benefits available to employees of of the University of Redlands, and is not intended to describe all the provisions of the official plan document. If there is any discrepancy between the information in this brochure and the official plan documents, the plan documents will prevail. University of Redlands reserves the right to modify or terminate these benefits at any time. Neither this communication nor the benefits offered represent a contract of employment and in no way restricts University of Redland's status as an at-will employer.

Employee & Dependent Benefits Eligibility

FACULTY: Faculty under written contract to carryout academic responsibilities equivalent to a minimum of a three-quarter time teaching load and have satisfied their waiting period are eligible for benefits.

ADMINISTRATORS & STAFF: All full-time regular employees who work at least 30 hours per week and 9 months per year and have satisfied their waiting period are eligible for benefits.

Eligibility for coverage is first of the month following, or coincident with, date of hire for all benefits except Basic Life/AD&D. Full-time employees are eligible for Basic Life/AD&D on date of hire.

DEPENDENTS: Eligible dependents include your Spouse, California Registered Domestic Partner and Children (natural, adopted, foster, stepchild, or a child placed with you for adoption), to age twenty-six (26) without regard to student, marital, dependency, residency, or employment status.

A change in Family Status allows special enrollment provisions and enables you to make mid-year changes to your annual benefits election, providing you make a change within 30 days of any of the following IRS-qualified Family Status changes:

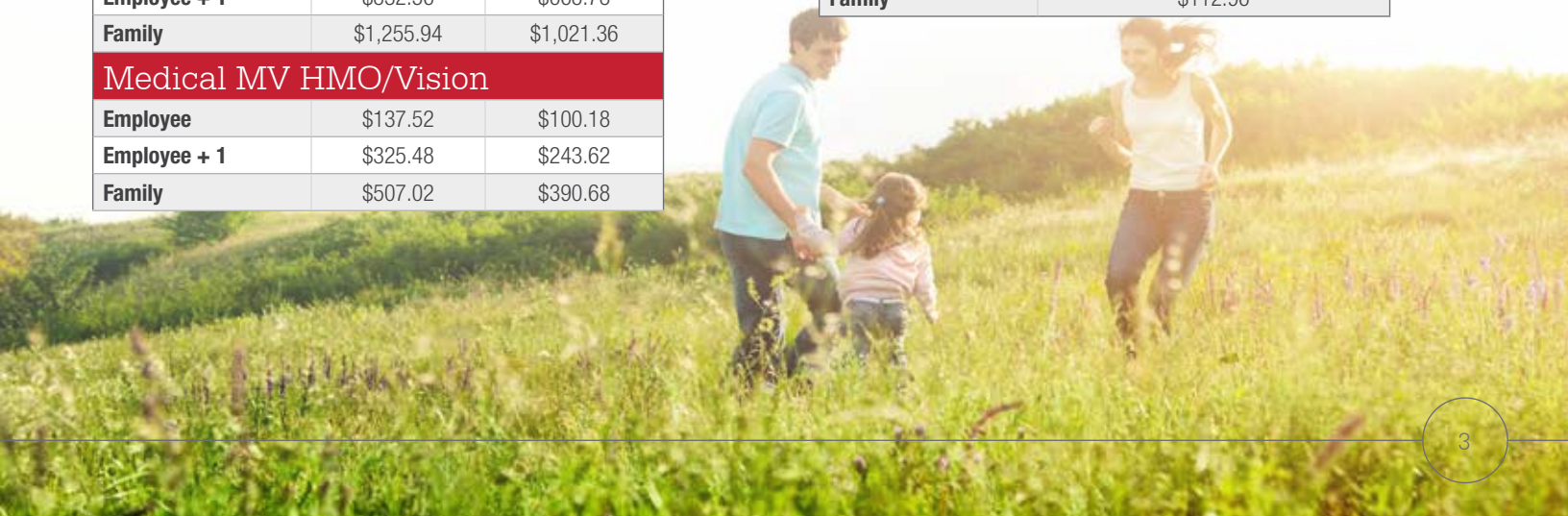
- Change in marital status,
- Death of spouse or dependent,
- Birth or adoption of child,
- Spouse terminating/obtaining new employment, or
- Spouse switching employment status (full-time to part-time or vice versa)

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. For further information, please review the Required Health Plan Notices booklet and/or visit www.medicare.gov.

2015/2016 Monthly Employee Contributions

Medical HMO/Vision	STANDARD RATES	HEALTH-U RATES
Employee	$163.28	$119.26
Employee + 1	$386.54	$290.02
Family	$602.26	$465.10
Medical HDHP/Vision		
Employee	$351.48	$276.96
Employee + 1	$832.56	$668.78
Family	$1,255.94	$1,021.36
Medical MV HMO/Vision		
Employee	$137.52	$100.18
Employee + 1	$325.48	$243.62
Family	$507.02	$390.68

Dental DHMO	
Employee	$7.68
Employee + 1	$18.42
Family	$25.18
Dental PPO	
Employee	$42.94
Employee + 1	$89.22
Family	$112.96



Aetna Medical Benefits

Three Plans To Choose From

The University of Redlands' comprehensive benefits package offers you three medical plans to choose from:

- Aetna HMO
- Aetna High Deductible Health Plan (HDHP) with Health Savings Account (HSA)
- Aetna Minimum Value HMO

Aetna HMO

When you enroll in Aetna's HMO Plan, you must select a contracting Physician Group where you want to receive your medical care. That Physician Group will provide or authorize all medical care. Your Aetna ID Card shows your selected contracting Physician Group's name, address and telephone number. Call them directly to make an appointment.

	HMO	Minimum Value HMO
Lifetime Maximum	Unlimited	Unlimited
Annual Deductible	None	$3,000 Individual / $6,000 Family
Out-of-Pocket Maximum **– Individual** **– Family**	 $1,500 $3,000	 $5,000 $10,000
Primary Care Physician (PCP) Office Visits	$30 Copay	$50
Specialist Office Visit	$40 Copay	$50
Routine Physical Exams and Well Child Exams/Immunizations	$0 copay – If services are performed as part of a physician's office visit and billed by the physician; expenses are covered subject to the applicable physician's office visit cost sharing	
Lab	$0 copay – If services are performed in physician's office as part of the office visit and billed by the physician. Otherwise, a $40 copay is required.	$0 copay – If services are performed in physician's office as part of the office visit and billed by the physician. Otherwise, a $50 copay is required.
X-Rays	$40 copay – If services are performed at a free-standing facility and billed by the facility, a separate $40 copay will be charged (in addition to the physician's office visit).	$0 copay (other than Complex Imaging Service) $150 copay (Complex Imaging Services)
Hospital Inpatient	$500 per admit Copay	60%
Outpatient Surgery	$250 Copay per visit	60%
Emergency Room	$100 Copay (waived if admitted)	$200 copay after deductible
Chiropractic (limited to 20 visits/cal. yr.)	$15 Copay	Not Available
Prescription Drugs (up to 30 day supply) **– Generic** **– Brand Name** **– Non-Formulary** **Mail Order (up to 31-90 day supply)**	 $10 Copay $30 Copay $50 Copay $20/Generic / $60 Brand / $100 Non-Formulary	 $20 Copay $35 Copay $50 Copay $40/Generic / $70 Brand / $100 Non-Formulary
Mental Health **– Inpatient** **– Outpatient**	 $500 per admit Copay $40 Copay	 60% per admission after deductible $50 copay
Alcohol & Drug Rehabilitation **– Inpatient** **– Outpatient**	 $500 per admit Copay; Detox Only; Rehabilitation $40 Copay per visit; Rehabilitation	 60% after deductible $50 Copay

Aetna High Deductible Health Plan (HDHP) w/HSA

The Aetna High Deductible Health Plan (HDHP) / HSA offers coverage for the employee who is looking for more choices. This plan provides coverage for both In-Network (Preferred) Providers and Out-of-Network (Non-Preferred) Providers.

	High Deductible Health Plan (HDHP)	
	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
Annual Deductible **– Individual** **– Family**	 $1,250 $2,500	 $1,750 $3,500
Out-of-Pocket Maximum **– Individual** **– Family**	 $2,500 $5,000	 $3,250 $6,500
Primary Care Physician/Specialist Office Visit	90%	70%
Preventive Care **Routine Physical Exams & Well Child Care/ Immunizations (age & frequency schedules)**	100%	70%
Lab & X-Rays	90%	70%
Hospital Inpatient	90%	70%
Outpatient Surgery	90%	70%
Emergency Room	90%	90%
Chiropractic (limited to 20 visits/cal. yr.)	90%	70%
Prescription Drugs (up to 30 day supply) **– Generic** **– Brand Name** **– Non-Formulary** **Mail Order (up to 31-90 day supply)**	After combined medical/Rx deductible $5 Copay $30 Copay $50 Copay $10/Generic / $60 Brand / $100 Non- Formulary Deductible waived for certain Preventive Medications: See List	Not Covered
Mental Health **– Inpatient** **– Outpatient**	 90% 90%	 70% 70%
Alcohol & Drug Rehabilitation **– Inpatient** **– Outpatient**	 90% 90%	 70% 70%

Dental Benefit

Regular dental care, which is as important to your health as medical care, can often be expensive. There are two plans for you to choose from, the Aetna DPPO Plan or the Aetna Prepaid DHMO Plan. Both plans provide comprehensive coverage, including diagnostic and preventive care, as well as basic and major procedures.

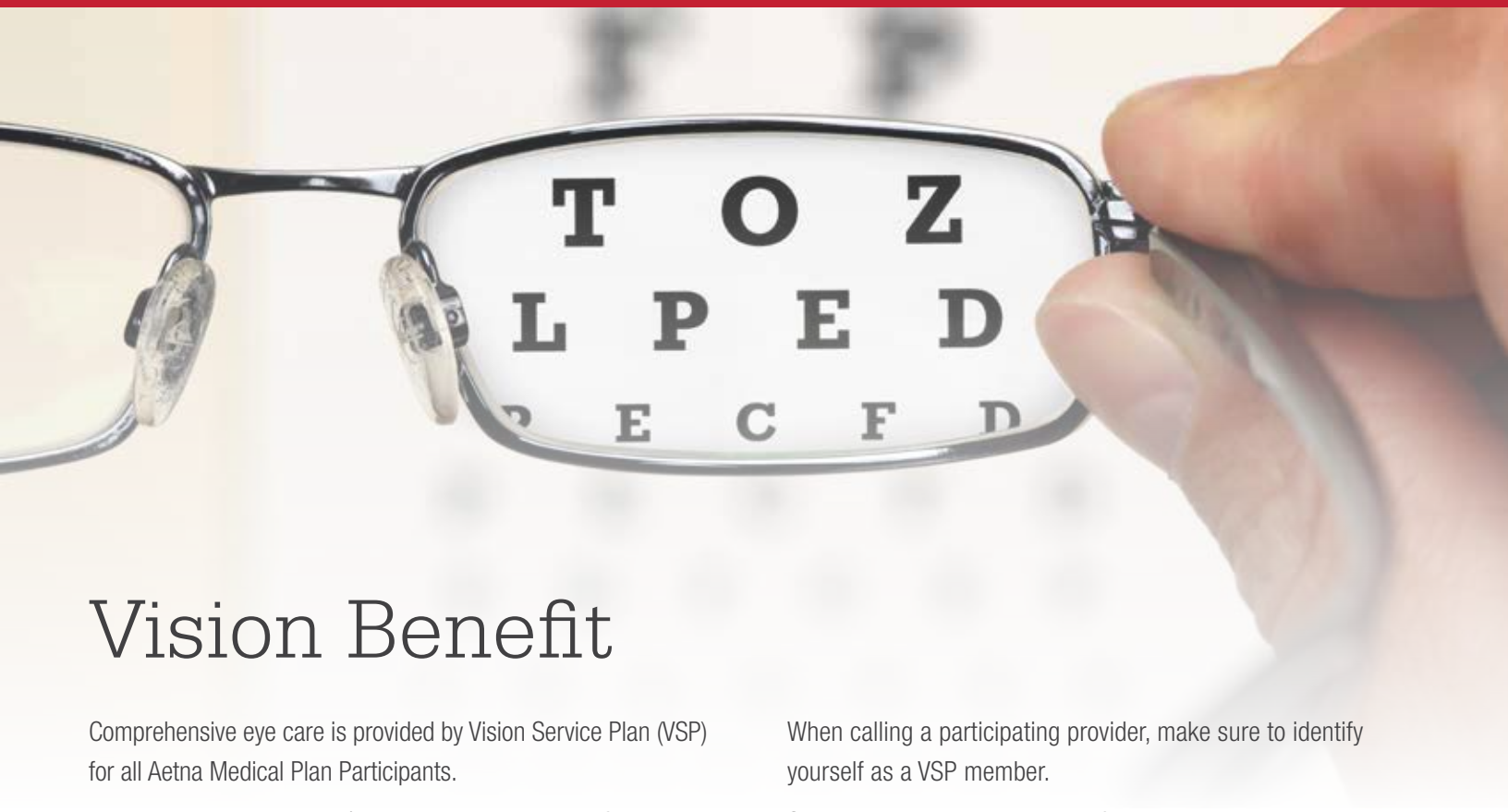
Aetna DPPO

With the Aetna DPPO Plan you may see a Preferred In-Network Provider and Aetna will pay benefits based upon a negotiated fee schedule (this will mean less out-of-pocket expense for you). You may also see a Non-Preferred Out-of-Network Provider and benefits will be based on usual, customary and reasonable rates (UCR). This plan has an annual deductible and maximum benefit amount. Covered diagnostic and preventive services do not count toward the annual plan maximum — leaving members with more benefit dollars to use for other covered services. Additional benefit information is provided in the table below.

Aetna DHMO

The Aetna DHMO Prepaid Plan features a network of participating general dentists and specialists who offer a full range of services. You are required to select a Primary Care Dentist when enrolling in this plan, as your Primary Care Dentist must perform all covered services and specialist referrals. There is no annual deductible. Your portion of the cost (copayment) depends on the type of service performed. Please refer to Aetna's enrollment materials for additional information.

	Aetna DPPO		**Aetna Pre-Paid DHMO**
	IN-NETWORK ADVANTAGE PLUS	OUT-OF-NETWORK	IN-NETWORK
Calendar Year Maximum	$1,500	$1,500	None
Calendar Year Deductible **– Individual** **– Family**	$50 $100		None
Type A Expenses *Routine Exams, Cleanings*	100%	100%	See Supplemental Copayment Schedule
Type B Expenses *Basic Restorative, Space Maintainers, Endodontics, Surgical and Non-surgical Periodontics, Simple Extractions, Repair of Crowns, Inlays/Onlays, Complex Oral Surgery, Bridges & Dentures*	90%	80%	See Supplemental Copayment Schedule
Type C Expenses *Crowns, Inlays/Onlays, Bridges, Prosthetics*	60%	50%	See Supplemental Copayment Schedule
Orthodontia (Child & Adult)	50%		$1,545 Copay
Lifetime Maximum	$2,000		N/A



Vision Benefit

Comprehensive eye care is provided by Vision Service Plan (VSP) for all Aetna Medical Plan Participants.

When an examination and/or materials are received from a participating VSP provider, you will have no out-of-pocket expense other than your copayment, unless optional items are selected. When you wish to obtain vision care services, you must call a VSP participating provider to make an appointment.

When calling a participating provider, make sure to identify yourself as a VSP member.

Services and materials obtained from a non-participating provider will be reimbursed up to the maximum scheduled amount. When you receive an examination and/or materials from a non-participating provider, you are responsible for paying the provider in full at the time of service. **You must submit itemized receipts to VSP for reimbursement.**

	Vision Service Plan (VSP)	
	IN-NETWORK	OUT-OF-NETWORK
Copay **Examination**	$10 Copay	Up to $45 Allowance
Benefit Frequency		
– Examination	12 months	N/A
– Lenses	12 months	N/A
– Frames	12 months	N/A
– Contacts (in lieu of Lenses & Frames)	12 months	N/A
Lenses & Frames (complete pair)		
– Single Vision Lens	20% Discount of UCR*	N/A
– Bifocal Lens	20% Discount of UCR*	N/A
– Trifocal Lens	20% Discount of UCR*	N/A
– Lenticular	20% Discount of UCR*	N/A
– Basic Progressive	20% Discount of UCR*	N/A
Contact Lenses (in lieu of Lenses & Frames)		
– Medically Necessary (certain medical conditions)	15% Discount of UCR*	N/A
– Elective (choice over eyeglasses)	15% Discount of UCR*	N/A

*UCR-Usual, Customary, and Reasonable charges.

Basic Life, Voluntary Life and AD&D Benefits

Life/AD&D insurance is an important part of your comprehensive benefits package. For peace of mind and the financial protection of your family, we provide financial protection for you and your family in the event of death or a serious accident through Sun Life. All full-time benefit eligible employees are automatically enrolled in the Basic Life and Accidental Death and Dismemberment Insurance Program; you must complete and sign a beneficiary form and return it to the Human Resources Department. You may also elect additional Voluntary Life and AD&D coverage as shown below. For all life insurance products, when the covered employee reaches age 65, his or her basic life, voluntary life, spouse / CA registered DP & AD&D benefits will be reduced to 65% of the benefit amount selected; at age 70, 45%; at age 75, 30%; at age 80, 20%.

Basic Life/AD&D
1 x annual salary, rounded to the next higher $1,000, up to $200,000 (employer paid)
Voluntary Life and AD&D (Employee)
$10,000 to $550,000, in increments of $10,000, to a maximum of 3 x annual salary or $550,000, whichever is less.
Amounts requested over $200,000 or to enroll after you are initially eligible, requires Evidence of Insurability.
If currently enrolled in Voluntary Life, you may increase your coverage amount each annual enrollment by $10,000 without Evidence of Insurability.
Voluntary Life (Spouse/California Registered Domestic Partner)
$5,000 to $275,000, in increments of $5,000, to the lesser of 50% of Employee amount or $275,000.
$25,000 is the Guarantee Issue amount.
Voluntary Life (Child)
$5,000
Voluntary AD&D (Employee)
$10,000 to $550,000, in increments of $10,000, to a maximum of $550,000.
Voluntary AD&D (Spouse/California Registered Domestic Partner)
50% of Employee amount if no dependent children.
40% of Employee amount if dependent children.
Maximum is $275,000.
Voluntary AD&D (Child)
15% of Employee amount if Spouse is not covered.
10% of Employee amount if Spouse is covered.
Maximum is $10,000.

Flexible Spending Accounts (FSAs)

A great way to save money over the course of a year is to participate in the Discovery Benefits Flexible Spending Accounts (FSAs). These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible expenses that are not reimbursed by your medical plan, deductibles, and dependent care expenses. Pre-tax means the dollars you use for eligible expenses are not subject to social security tax, federal income tax and, in most cases, state and local taxes. Money you would have paid in taxes can be used to pay qualified expenses.

Health Care Reimbursement

You may contribute up to $2,500 per plan year (July–June) in a Health Care Reimbursement Account. The Health FSA is for use with a traditional insurance plan such as a HMO to pay for things not covered by your medical, dental and vision plans, such as deductibles, copays, prescriptions and vision services. The Limited Health FSA is for use with the HDHP along with a health savings account (HSA) to pay for qualified dental and vision out-of-pocket expenses.

1. Pay upfront and get reimbursed.
   - » Pay for services and products.
   - » Submit reimbursement, proof of purchase and dates and type of service (also called substantiation).
   - » Have your funds automatically deposited into your checking or savings account, or receive a check.
2. Pay eligible expenses with your Discovery Benefits Debit Card.
   - » Use your Discovery Benefits Debit Card to pay for eligible services and products.
   - » Payments are automatically withdrawn from your FSA, so you don't incur out-of-pocket costs.
   - » Discovery Benefits Debit Card purchases must be verified to satisfy the IRS. Some merchants can provide all the IRS-required information right at the point of sale. Other purchases will need to be verified with receipts and dates and type of service.

Please note: If you are enrolling in the Aetna High Deductible Health Plan (HDHP) w/HSA, please see the University of Redlands' Election Form and Compensation Redirection Agreement for additional information.

Dependent Care Reimbursement

You may contribute up to $5,000 or up to $2,500 if you are married and file separate tax returns per calendar year. Eligible dependent care expenses are for the care of children under age 13, or dependents of any age that are unable to care for themselves because of a mental or physical handicap. The services must be necessary to allow you, or you and your spouse if you are married, to work or attend school full-time.

Important Rules

In exchange for the tax advantages, the IRS has strict rules about how these accounts work. You may not stop or change your contribution amounts until the next Annual Enrollment, unless you have an IRS-qualified Family Status change. Any funds remaining in the accounts after September 15th of the following plan year are forfeited. Expenses for the plan year must be submitted no later than 90 days after the end of the plan year. The Health Care Reimbursement Account and the Dependent Care Reimbursement Account function separately; funds may not be transferred from one to the other.

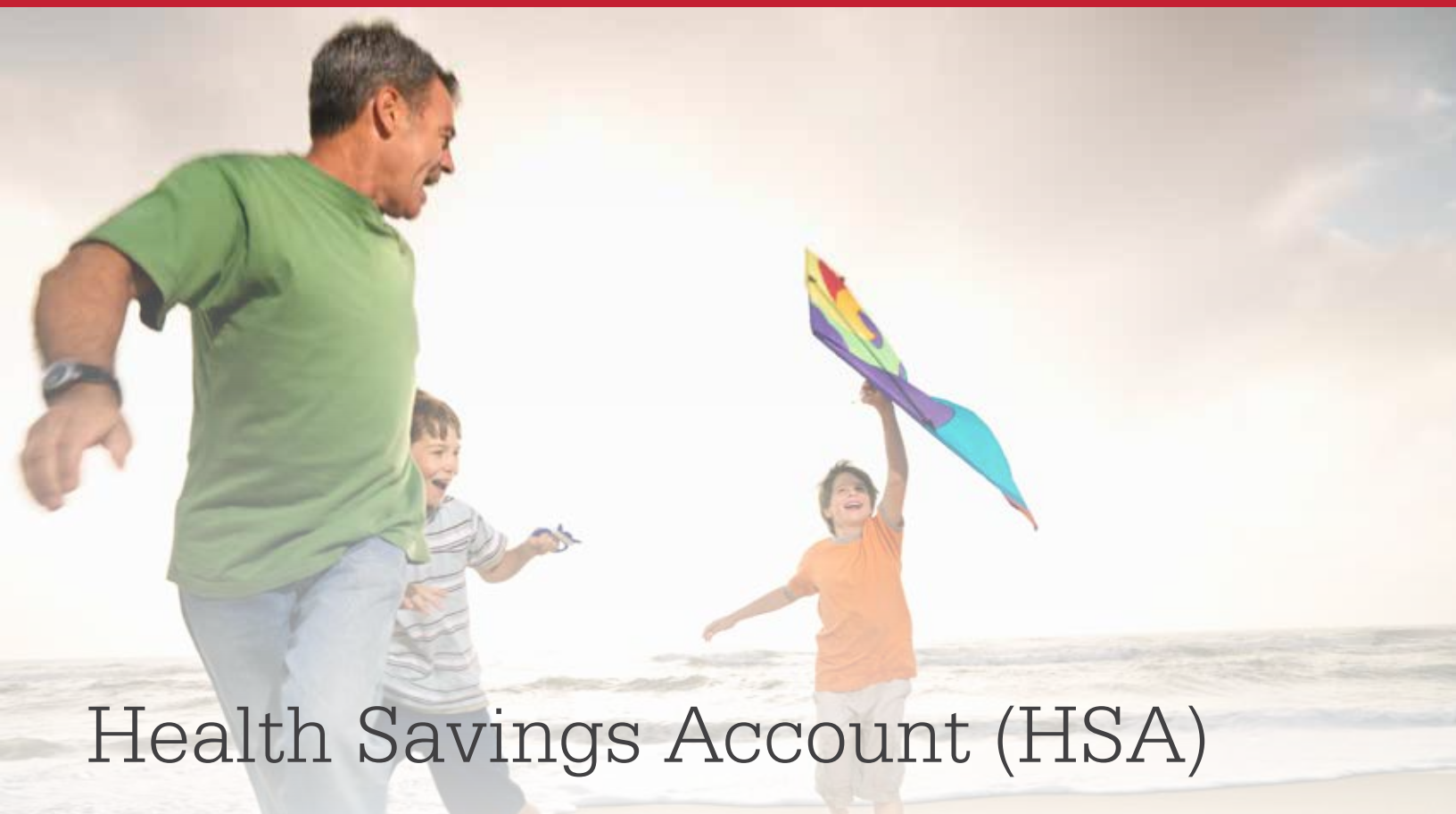
The Discovery Benefits Debit Card

When you choose to open a FSA you now have the added benefit option to participate in the debit card program. Your Discovery Benefits debit card can be utilized at health care related merchants such as hospitals, vision, dental, and doctor's offices. In addition to these locations, the card can be utilized at drugstores, pharmacies, and grocery stores that have implemented the IIAS (Inventory Information Approval System) or certified 90% of their gross sales are FSA eligible. You can find this list at: www.discoverybenefits.com/iias

Using your card is a quick and easy way to pay for eligible expenses: Step 1: Use your Discovery Benefits Card to pay for eligible service and products. Payments are automatically withdrawn from your reimbursement account, so there are no out-of-pocket costs. Step 2: Verify or substantiate your purchase (required by the IRS). Some merchants can provide all the IRS-required information right at the point of sale. In some cases, a medical necessity form may be required when the expense is considered either a medical expense or a personal use item. Remember to retain your receipts in case you are later asked for verification of the purchase.

Receive two cards when you enroll. Additional cards may be requested for those dependents age 18 or older for free.

Helpful Hint: Don't use the card for amounts that still need to be processed by insurance, such as deductibles and coinsurance. When you receive your final statement from the provider showing insurance has paid, write your Discovery Benefits Debit Card number on the statement and mail to: Discovery Benefits, P.O. Box 2926 Fargo North Dakota 58108-2926 or if you have questions you may contact them at 866.451.3399.



Health Savings Account (HSA)

An HSA is an account that you can put money into to save for future medical expenses. It is a medical benefits plan AND a savings account, all in one. There are certain advantages to putting money into these accounts, including favorable tax treatment. HSAs were signed into law by President Bush on December 8, 2003.

Who is Eligible for an HSA?

To be eligible for an HSA you must meet the following IRS requirements:

- You must be covered by an HSA-qualified "high deductible health plan" (HDHP) as defined by Federal Law
- Have no other first-dollar medical coverage (other types of insurance like specific injury insurance or accident, disability, dental care, vision care, or long-term care insurance are permitted)
- You cannot be claimed as a dependent on someone else's tax return
- To be eligible for an HSA you cannot be enrolled in Medicare and receiving Social Security Benefits.

High Deductible Health Plans (HDHPs). You must have coverage under an HSA-qualified "high deductible health plan" (HDHP) to open and contribute to an HSA. Generally, this is health insurance that does not cover first dollar medical expenses. In general, the deductible must apply to all medical expenses (including prescriptions) covered by the plan. However, plans can pay for "preventive care" services on a first-dollar basis (with or without a copay). "Preventive care" can include routine pre-natal and well-child care, child and adult immunizations, annual physicals, mammograms, pap smears, etc. Please refer to Discovery Benefits Plan Design and Benefits Summary and to the Preventive Medications list for HDHP/HSA plans.

You have the protection of a medical and prescription drug benefits plan; plus you get a tax-advantaged health savings account that you can use to help pay for qualified expenses.

HSA Employee Contribution. You can make a contribution to your HSA each year that you are eligible. You can contribute up to $3,350 for single coverage and $6,650 for employee + 1 or more dependent coverage. Individuals age 55 and older can also make additional "catch up" contributions. The maximum annual catch-up contribution for 2015/2016 is $1,000.

HSA Employer Contribution. For the 2015/2016 Plan Year, the University will contribute $450 for Employee Only coverage, $600 for Employee + 1 dependent, and $750 for Employee + 2 or more dependents, per plan year to employees earning $75,000 and under annually, prorated on the number of months of participation, to each participant's Health Savings Account.

Determining Your Contribution. Your eligibility to contribute to an HSA is determined by the effective date of your HDHP coverage. If you are eligible to make HSA contributions for December, you are DEEMED to have been eligible for the entire year. If you take advantage of the deeming rule and make additional contributions, you must REMAIN eligible to make HSA contributions for the ensuing calendar year or pay an excise tax on the additional contribution made. If you are only eligible to make HSA contributions for only a portion of a year, and not for the month of December, all contributions (including catch-up contributions) must be pro-rated. Your annual contribution depends on the number of months of HDHP coverage you have during the year (counting only the months where you have HDHP coverage on the first day of the month).

Using your HSA. You can use the money in the account to pay for any "qualified medical expense" permitted under federal tax law. This includes most medical care and services, and dental and vision care.

You can also use the money to pay for COBRA continuation coverage after leaving employment, qualified long-term care insurance, Medicare premiums and out-of-pocket expenses including deductibles and copays.

Your account money can be used to pay for medical expenses for yourself, your spouse, or your dependent children even if they are not covered by your HDHP.

ADVANTAGES OF AN HSA

Security – your HDHP insurance and HSA protects against high or unexpected medical bills.

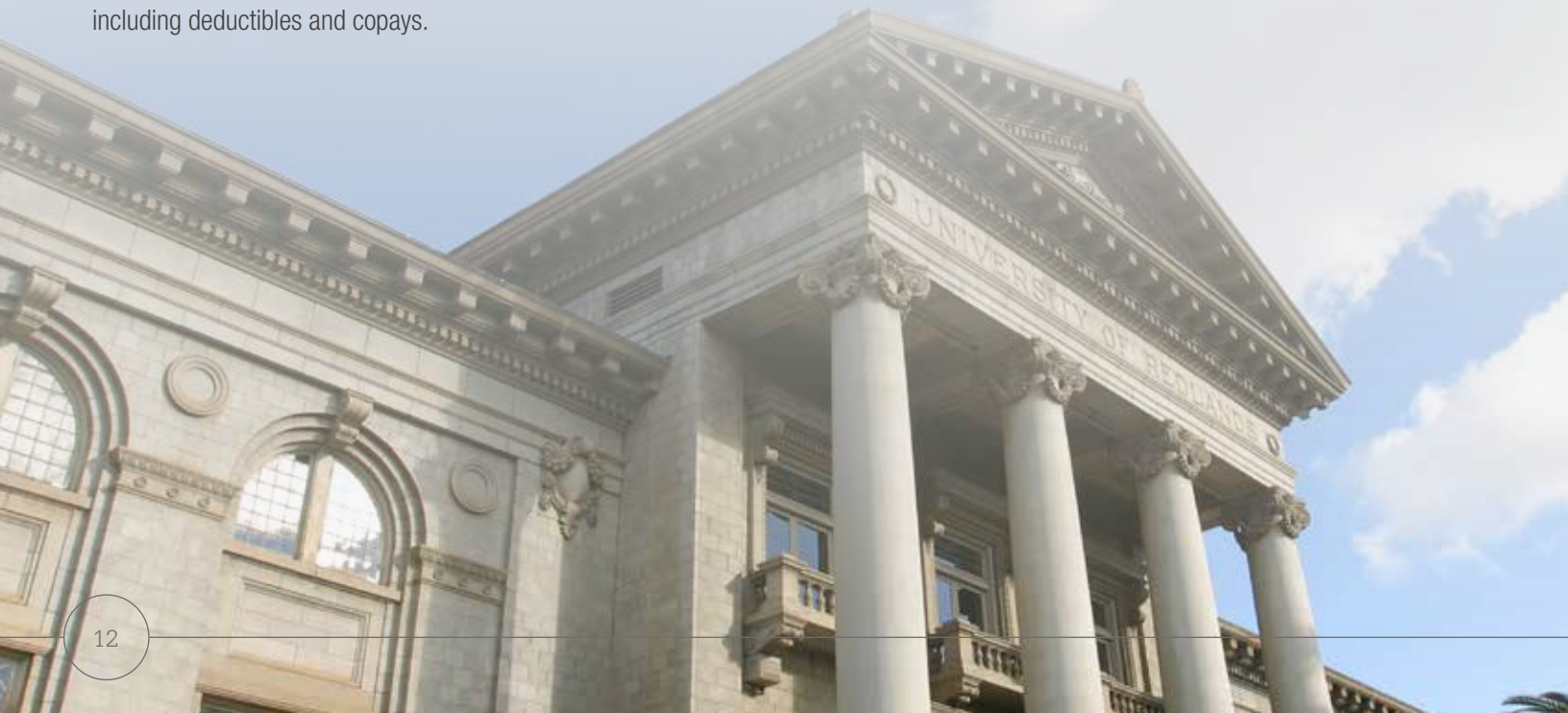
Savings – save money in your account for future medical expenses and grow your account through investment earnings.

Control – you decide how much money to save – pay current medical expense or save the account for future expenses.

An HSA provides you triple tax savings: tax deductions when you contribute, tax-free earnings through investment and tax-free withdrawals for qualified medical expenses.

Contributions remain in your account from year to year, just like an IRA.

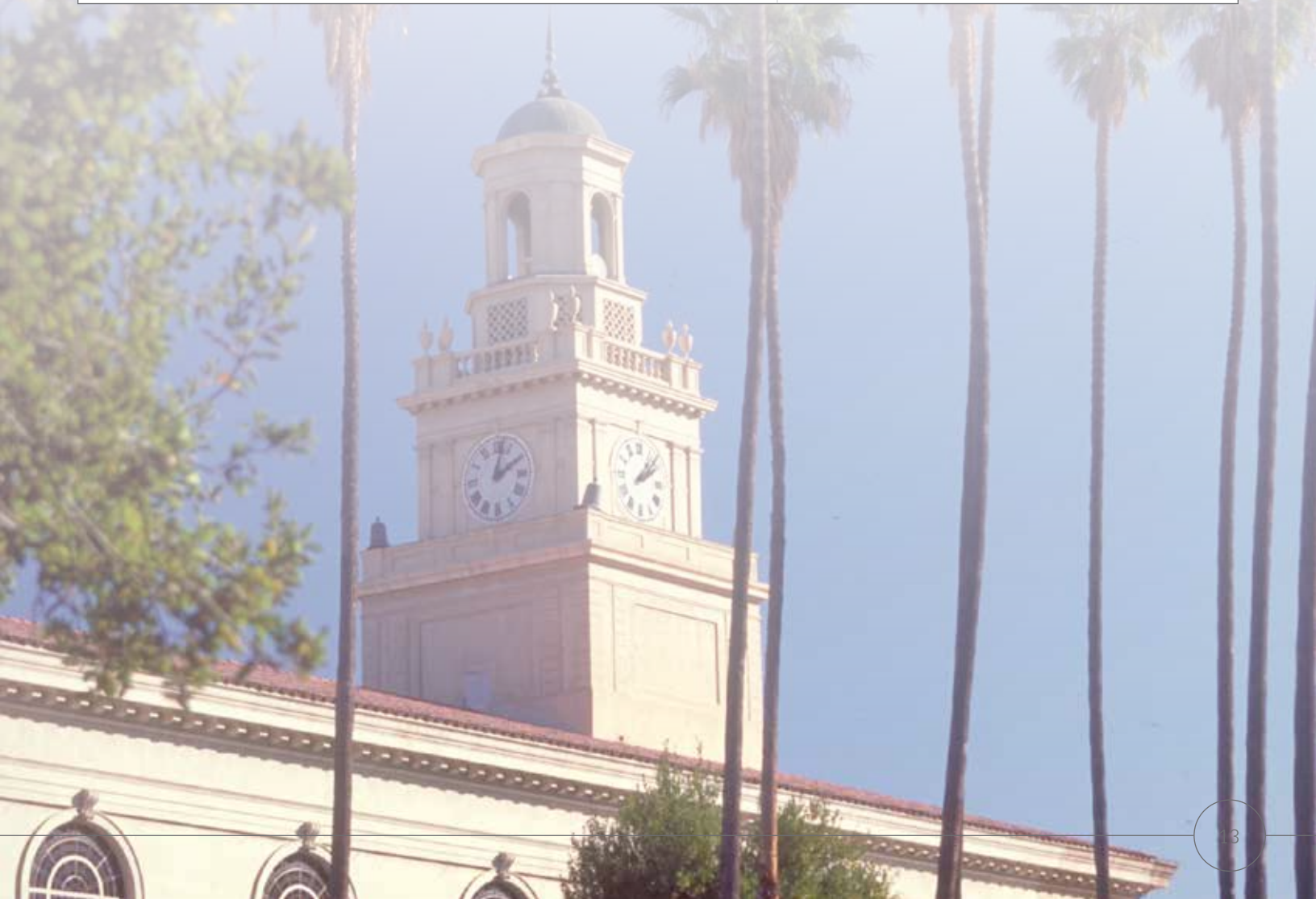
An HSA is "portable" so it stays with you if you change jobs or leave the work force.

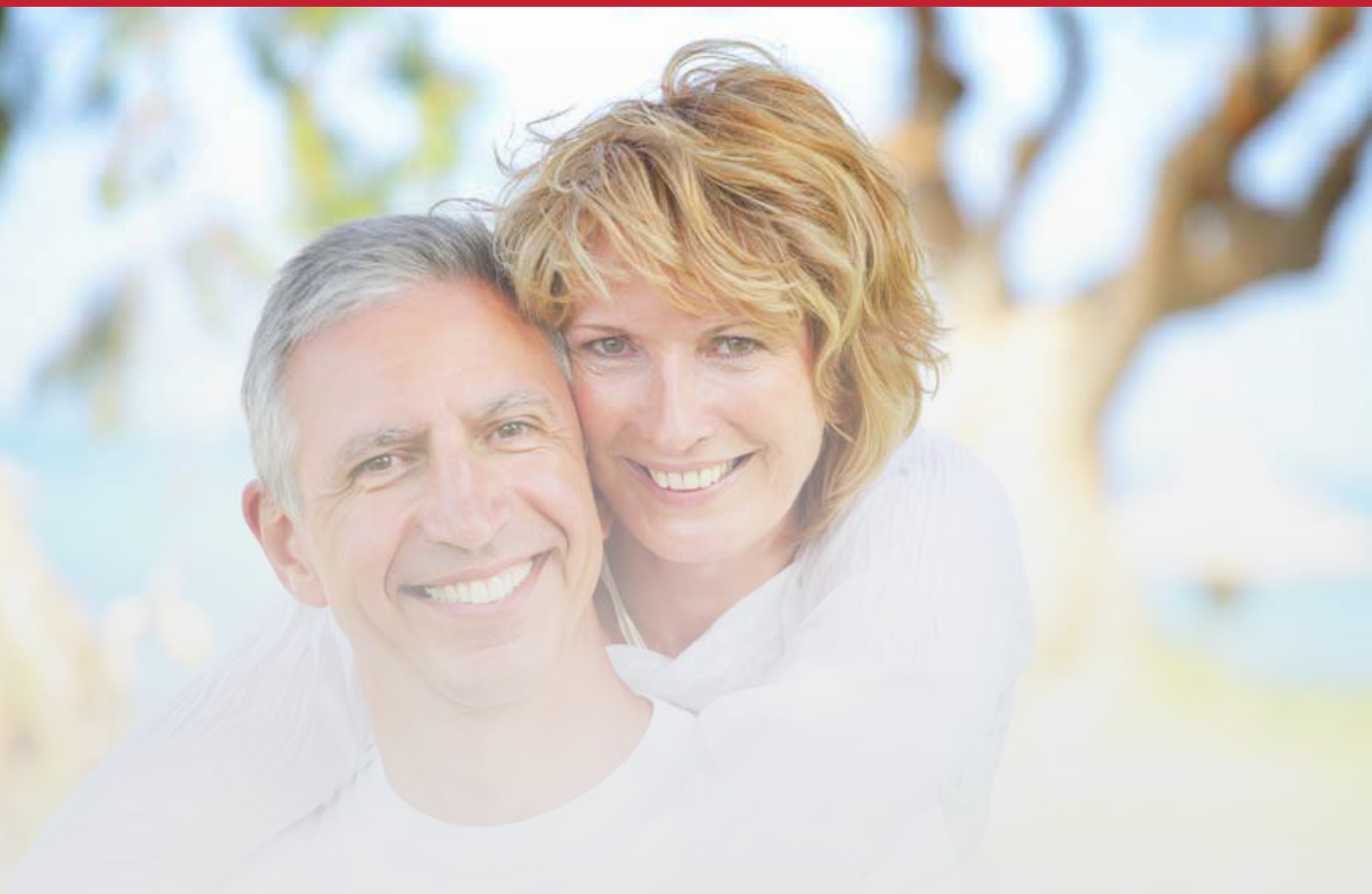


Employee Assistance Program (EAP)

Dealing with the pressures of everyday life (family, work, finances, etc.) can sometimes require professional assistance. This employer-paid program provides a resource for you and your family to improve and maintain their physical and emotional well-being through professional counseling. Topics of discussion can include, but are not limited to, personal issues, legal counseling, financial counseling, child care and elder care. Your Cigna Behavioral Health EAP Representative can also refer you to a qualified counselor. You have access to free telephone consultations. An EAP Representative can be reached 7 days a week, 24 hours a day. All information discussed is strictly confidential.

COVERAGE	Cigna Behavioral Health
Number of Visits Per Policy Year	8 face-to-face sessions per incident
Visits Referred by Licensed Clinician	Included
Personal and Workplace Stress/Conflict Resolution	Included
Legal Resource and Referral Services	Included
Financial Counseling Resource	Included
Child Care Referral Services	Included
Elder Care Referral Services	Included
Health Management Programs (Smoking Cessation, etc.)	Not Included
Health Events & Emotional Well-Being Online	Included





Additional Benefits

Long Term Disability (LTD)

This plan is offered to you through Sun Life and provides a source of income if you are disabled for 90 days or more due to an illness or injury. The plan pays up to 60% of your pay up to a maximum LTD benefit of $6,000 per month. The University of Redlands will pay 50% of the premium cost should you want to participate.

Business Travel Accident

This plan is offered to you through The Hartford and provides a $50,000 benefit to all active full-time employees traveling on official University of Redlands business under a Business Travel Accident policy.

Retirement Summary

In accordance with the Retirement Plan Document, eligible employees will receive a University paid contribution into their retirement account. The amount is 100% vested. All employees may contribute pre-tax dollars into their retirement account. Effective January 1, 2010, all employees may contribute after-tax dollars, Roth 403(b), into their retirement account as well. The maximum contribution for the combined pre- and after-tax dollars for 2015 is $18,000, for employees who have 15 or more years of service at the University of Redlands and would like to contribute more than $18,000 should contact Human Resources for more information. If you are 50 years or older as of December 31, 2015, you may contribute an additional $6,000. TIAA-CREF is the University's sole retirement provider.

Your Wellness Program

The University of Redlands is committed to a health care strategy that emphasizes a culture of health and personal responsibility. Since the introduction of our enhanced wellness program in the Spring of 2012 feedback from our employees has been overwhelmingly positive. Our wellness program is among one of the best in the nation and is considered to be a leading program in the area of health management. Healthy U provides a platform to support members with the tools and resources needed to create a healthy lifestyle. Designed to help you manage your personal fitness goals and programs from beginning to end, Healthy U solutions are a unique combination of comprehensive health assessments, employee incentives, creative engagement and strategies.

By partnering with you, Healthy U offers products that engage meaningful health management programs designed to improve lives! With the confirmation of the Affordable Care Act, we must focus our plan designs around risk reduction and incentivize employees for behavior change. As the rising cost of health care continues to be a nationwide concern, the University of Redlands feels strongly that the focus needs to be on prevention and to help employees not only drive down the their personal cost for health care, but also to help our employees live a richer healthier lifestyle.

We believe Healthy U will help energize you to stay healthy through a culture of health in the workplace by developing meaningful health management programs that drive strong participation to effectively prevent, identify, address and reduce health risks before they turn into significant medical expenses.

Good Health, Long Life, More Energy & Greater Happiness!

For good health, long life, more energy and greater happiness, among many other benefits, the importance of regular exercise and a proper diet can't be understated. These two factors together are the most pivotal when determining a person's overall health, and adopting them both can make a dramatic difference in how you look and feel.

Health Benefits

According to the U.S. Department of Health and Human Services, a healthy diet means eating lots of fruits, vegetables, whole grains, low-fat dairy products and lean meats and minimizing the consumption of cholesterol, sodium, sugar and saturated fat. In conjunction with regular exercise, a healthy diet can reduce your risk of heart disease, osteoporosis, type-2 diabetes, high blood pressure and some cancers.

Weight

If you're overweight, eating healthy and exercising regularly can help you lose weight safely and keep it off. And if you don't have a weight problem, physical activity and a healthy diet can help you maintain your current weight and reduce your risk of gaining extra weight in future years. Healthy foods are generally lower in calories and higher in nutrients than other foods, and regular physical activity burns off extra calories and keeps your metabolism healthy.

Energy

According to the National Institute of Diabetes and Digestive and Kidney Diseases, a combination of working out and eating healthy foods can boost your energy level as well as help you feel more alert and aware, both mentally and physically. Healthy foods give your body the nutrients and vitamins it needs to function at its best, and even though you use calories and energy through physical activity, the process actually increases the total amount of energy you have.

Mood

Exercise stimulates brain chemicals that help produce feelings of happiness, contentment and relaxation, so you'll feel better if you workout on a regular basis. According to the Mayo Clinic, physical activity also makes you look better, which is a significant factor in boosting self-confidence and instilling a more positive outlook on life.

Private College 529 Plan℠

Tomorrow's Tuition at Today's Prices—GUARANTEED

Take Rising Tuition Costs Out of the Equation

Private College 529 Plan is the only guaranteed way to lock in today's tuition rates at a diverse group of more than 270 private colleges across the country.

The Plan is structured as a pre-purchase of tuition—not an investment. That means:

- No investments to choose
- No performance indicators to watch
- No worries about a market downturn.

Instead, you purchase certificates at today's prices that can be redeemed for tuition at any of the Plan's participating schools for up to 30 years. Should your child opt for a public college or a non-member private college—or if she doesn't attend college at all—you can change the beneficiary, roll the account into another 529 plan or request a refund.

Pay less by paying today

Paying today may help you save substantially on the cost of college tuition. Simply put, if tuition continues to rise at a rate of 5% per year, the power of your savings effectively grows 5% per year, federal tax free. Participants can enroll in the plan at any time and contribute as little as $25.00 a month. Contributions are refundable.

Access a large—and growing—network of schools

The Plan's ever-growing network of participating colleges and universities, located throughout the U.S., provides access to a wide range of different types of institutions, including many of the nation's top ranked schools.

Enroll Today

Visit **www.Redlands.edu/529Plan** today for complete plan details, answers to frequently asked questions and to enroll online in less than 15 minutes. You can also call (888) 718-7878 to speak with a representative.

If you want the benefits of a private college education for your child, grandchild, niece, nephew or other beneficiary of your choice but are concerned about the rising cost of tuition, Private College 529 Plan may be the answer.

Important Notices

Company Name (the "Company")

University of Redlands

Effective Date

July 1, 2015

Creditable Plan Name(s)

University of Redlands Health and Welfare Benefits Plan

Plan Administrator

University of Redlands
Human Resources
1200 East Colton Avenue
Redlands, CA 92373
909-748-8040

HIPAA Privacy Official

Roberta Dellhime
Director, Human Resources
909-748-8040

HIPAA Special Enrollment Deadline

30 days

Members of Organized Health Care Arrangement

Aetna — Medical
Aetna — Dental
VSP — Vision
Sun Life — Basic Life, AD&D, Optional Life, LTD
Cigna — EAP
Discovery Benefits—FSA & HSA
Lockton Insurance Brokers, LLC

COBRA Plan Administrator

ADP
5800 Windward Pkwy
Alpharetta, CA 30005
770-360-2000

COBRA Qualifying Event Period

30 days

Women's Health and Cancer Rights Notice

The Company is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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 lymphedemas.

The Company's plan(s) provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator.

HIPAA Notice of Privacy Policy and Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is provided to you on behalf of the Company about the Plan. It pertains only to health care coverage provided under the Plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official), and will be posted on any website maintained by the Company that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Other Uses and Disclosures of Your PHI Not Requiring Authorization

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as the Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.
- **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to Have an Opportunity to Object

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To choose how the Plan contacts you:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan

or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed on the first page of these notices. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see first page). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Organized Health Care Arrangement Designation

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

HIPAA Notice of 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, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment by the HIPAA Special Enrollment Deadline after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 by the HIPAA Special Enrollment Deadline, after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator. Note: Additional information may be required if the plan requires that persons declining coverage under the plan state, in writing, the reason(s) for declining coverage.

Notice B: Family Care & Medical Leave & Pregnancy Disability Leave

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with your employer and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 work-weeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse.

Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take pregnancy disability leave (PDL) of up to four months, or the working days in one-third of a year or 17 weeks, depending on your period(s) of actual disability. Time off needed for prenatal or postnatal care; doctor-ordered bed rest; gestational diabetes; pregnancy-induced hypertension; preeclampsia; childbirth; postpartum depression; loss or end of pregnancy; or recovery from childbirth or loss or end of pregnancy would all be covered by your PDL.

Your employer also has an obligation to reasonably accommodate your medical needs (such as allowing more frequent breaks) and to transfer you to a less strenuous or hazardous position if it is medically advisable because of your pregnancy.

If you are CFRA-eligible, you have certain rights to take BOTH PDL and a separate CFRA leave for reason of the birth of your child. Both leaves guarantee reinstatement to the same or a comparable position at the end of the leave, subject to any defense allowed under the law. If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or a family member). For events that are unforeseeable, you must to notify your employer, at least verbally, as soon as you learn of the need for the leave.

Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

Your employer may require medical certification from your health care provider before allowing you a leave for:

- your pregnancy;
- your own serious health condition; or
- to care for your child, parent, or spouse who has a serious health condition.

See your employer for a copy of a medical certification form to give to your health care provider to complete.

When medically necessary, leave may be taken on an intermittent or a reduced work schedule. If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.

Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. Contact your employer for more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits.

Important Notice from the Company About Your Prescription Drug Coverage and Medicare under the Creditable Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. The Company has determined that the prescription drug coverage offered by the Creditable Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period, you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed at the beginning of this document.

Coordinating Other Coverage with Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Company Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Company Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or Web address listed below.

If you do decide to join a Medicare drug plan and drop your prescription drug coverage with , be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For more information about this notice or your current prescription drug coverage…

Contact the Plan Administrator for further information. **Note:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Company changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

Wellness Program & Reasonable Alternative Standard

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Continuation Coverage Rights Under COBRA

You are receiving this notice because you have recently become covered under a group health plan, including a healthcare flexible spending arrangement (the Plans). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plans. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 listed at the end of this section.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 Plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 the COBRA Qualifying Event Period, after the qualifying event occurs. You must provide this notice to the Plan Administrator listed at the beginning of these notices.

How is COBRA Coverage Provided?

Generally, 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. In fact, notwithstanding any other provision of this Notice to the contrary, with respect to a health flexible spending account COBRA coverage will not be offered—notwithstanding the fact that a qualifying event has occurred—if as of the date of the qualifying event the health FSA account is in a "negative" position (that is, the participant has contributed for the year an amount less than the amount of claims paid from the account for the year, as of the date of the qualifying event).

If COBRA coverage is offered (because the health FSA account is in a "positive" position on the date of the qualifying event), the duration of COBRA coverage is limited to the end of the health FSA's fiscal year in which the qualifying event occurs. No additional COBRA coverage is provided, even if during the COBRA coverage period a second qualifying event occurs.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified at the beginning of this document. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Plan Administrator.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

ALABAMA – Medicaid

web: medicaid.alabama.gov
tel: 1-855-692-5447

ALASKA – Medicaid

web: dhss.alaska.gov/dpa/Pages/medicaid
tel: (Outside of Anchorage) 1-888-318-8890
tel: (Anchorage) 907-269-6529

ARIZONA – CHIP

web: www.azahcccs.gov/applicants
tel: (Outside of Maricopa County) 1-877-764-5437
tel: (Maricopa County) 602-417-5437

COLORADO – Medicaid

web: www.colorado.gov
tel: (In state) 1-800-866-3513
tel: (Out of state) 1-800-221-3943

FLORIDA – Medicaid

web: www.flmedicaidtplrecovery.com
tel: 1-877-357-3268

GEORGIA – Medicaid

web: dch.georgia.gov/health-insurance-premium-payment-program-hipp
tel: 1-800-869-1150

IDAHO – Medicaid

web: healthandwelfare.idaho.gov/Medical/Medicaid
tel: 1-800-926-2588

INDIANA – Medicaid

web: www.in.gov/fssa
tel: 1-800-889-9949

IOWA – Medicaid

web: dhs.state.ia.us/hipp
tel: 1-888-346-9562

KANSAS – Medicaid

web: www.kdheks.gov/hcf
tel: 1-800-792-4884

KENTUCKY – Medicaid

web: chfs.ky.gov/dms
tel: 1-800-635-2570

LOUISIANA – Medicaid

web: new.dhh.louisiana.gov/index.cfm/page/227
tel: 1-888-695-2447

MAINE – Medicaid

web: www.maine.gov/dhhs/ofi/public-assistance
tel: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

web: www.mass.gov/MassHealth
tel: 1-800-462-1120

MINNESOTA – Medicaid

web: mn.gov/dhs — *Select "A-Z Topics" then "Medical Assistance"*
tel: 1-800-657-3629

MISSOURI – Medicaid

web: dss.mo.gov/mhd/participants/pages/hipp.htm
tel: 573-751-2005

MONTANA – Medicaid

web: medicaid.mt.gov/member
tel: 1-800-694-3084

NEBRASKA – Medicaid

web: www.ACCESSNebraska.ne.gov
tel: 1-800-383-4278

NEVADA – Medicaid

web: dwss.nv.gov
tel: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

web: www.dhhs.nh.gov/oii/documents/hippapp.pdf
tel: 603-271-5218

NEW JERSEY – Medicaid and CHIP

web: (Medicaid) www.state.nj.us/humanservices/dmahs/clients/medicaid
tel: (Medicaid) 609-631-2392
web: (CHIP) www.njfamilycare.org
tel: (CHIP) 1-800-701-0710

NEW YORK – Medicaid

web: www.nyhealth.gov/health_care/medicaid
tel: 1-800-541-2831

NORTH CAROLINA – Medicaid

web: www.ncdhhs.gov/dma
tel: 919-855-4100

NORTH DAKOTA – Medicaid

web: www.nd.gov/dhs/services/medicalserv/medicaid
tel: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP

web: www.insureoklahoma.org
tel: 1-888-365-3742

OREGON – Medicaid

web: www.oregonhealthykids.gov
web: (Spanish) www.hijossaludablesoregon.gov
tel: 1-800-699-9075

PENNSYLVANIA – Medicaid

web: www.dpw.state.pa.us/hipp
tel: 1-800-692-7462

RHODE ISLAND – Medicaid

web: www.eohhs.ri.gov
tel: 401-462-5300

SOUTH CAROLINA – Medicaid

web: www.scdhhs.gov
tel: 1-888-549-0820

SOUTH DAKOTA - Medicaid

web: dss.sd.gov
tel: 1-888-828-0059

TEXAS – Medicaid

web: www.gethipptexas.com
tel: 1-800-440-0493

UTAH – Medicaid and CHIP

web: health.utah.gov/upp
tel: 1-866-435-7414

VERMONT– Medicaid

web: www.greenmountaincare.org
tel: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

web: (Medicaid) www.virginiamedicaid.dmas.virginia.gov
tel: (Medicaid) 1-800-432-5924
web: (CHIP) www.coverva.org
tel: (CHIP) 1-866-873-2647

WASHINGTON – Medicaid

web: www.hca.wa.gov/medicaid/premiumpymt
tel: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

web: www.dhhr.wv.gov/bms/
tel: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid

web: www.badgercareplus.org/pubs/p-10095.htm
tel: 1-800-362-3002

WYOMING – Medicaid

web: health.wyo.gov/healthcarefin/equalitycare
tel: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137

Notes

Notes

Important Carrier Contact Information

Provider	Benefit Coverage	Telephone	Website
Aetna	HMO Minimum Value HMO High Deductible Health Plan (HDHP) w/ HSA Rx Member Services Dental Pre-Paid DHMO & Dental DPPO	888-247-1024 888-247-1024 877-392-3862 888-792-3862 877-238-6200	www.aetna.com
California Casualty	Auto & Home Insurance	877-999-8949	www.calcas.com
Cigna Behavioral Health	Employee Assistance Program (EAP)	888-371-1125	www.cignabehavioral.com
Discovery Benefits	Health Savings Account (HSA) Flexible Spending Account (FSA)	866-451-3399	www.discoverybenefits.com
Private College 529 Plan	Tuition Plan	888-718-7878	www.Redlands.edu/529Plan
Sun Life Financial	Life and Accidental Death and Dismemberment (AD&D) Long-Term Disability (LTD)	800-247-6875	www.sunlife.com
TIAA CREF	Retirement Services	800-842-2776	www.tiaa-cref.org
Vision Services Plan (VSP)	Vision	800-877-7195	www.vsp.com
24 PetWatch	Pet Insurance	866-370-7387	www.covermewithcare.com
Viverae	Wellness Program	888-848-3723	www.myviverae.com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