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2027 BENEFITS GUIDE

Welcome to Your Benefits Guide

This guide is intended as a quick reference of the benefits available to you through Academy of Art University. It is important that you take the time to understand your options, ask questions, and make your choices accordingly.

The details of the benefit plans described in this guide are contained in the official plan and policy documents, including insurance contracts. This guide is only meant to highlight major points of each plan and does not contain all the policy provisions, limitations and exclusions that are included in the official plan documents and Summary Plan Descriptions (SPD).

If there is ever a question about any of these plans or policies, or if there is a conflict between the information contained in this benefits guide and the official plan documents, the plan documents will govern.

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Your Benefits at Academy of Art University

At Academy of Art University, we believe our employees are our most valued asset, and our Benefits and Human Resources team strive to offer a comprehensive and competitive benefits program designed to protect the health and welfare of you and your loved ones. With the help of outside consultants and data resources, we continually examine the value of our benefit plans to be sure we are keeping pace with market trends and innovative approaches to health care and the financial well being of our staff.

While health care is an important component of any benefits program, Academy of Art University also offers a wide array of other benefit options. This guide provides an overview of the benefits program, followed by descriptions of the primary features of each benefit type. Please use this guide as an easy tool to help you make your benefit choices, and consult each carrier's Summary Plan Description, or booklet, for more in-depth descriptions of coverage. Remember too that your coverage needs may change from year to year as your family situation changes. During each annual Open Enrollment—held each Fall for a January 1 effective date—you should reevaluate your benefit elections and determine whether they still meet your needs. **This year's Open Enrollment is Passive: Your current elections will automatically carry over into 2027. Exception: Flexible Spending Account (FSA) elections do not carry over. You must take action if you want an FSA in 2027.**

WHO IS ELIGIBLE

All full-time employees are eligible for benefits. Part-time employees who work an average of at least 30 hours per week in a one year measurement period are also eligible for benefits. You may enroll your eligible dependents for Medical, Dental, and Vision, Life and AD&D. Your eligible dependents include:

- Your spouse or registered domestic partner.*
- Your children up to age 26, including children of your registered domestic partner.*
- Any dependent child who is incapable of self-support due to a mental or physical disability.

*Coverage for a domestic partner may have tax implications; contact Human Resources for details.

TERMINATION OF COVERAGE

Your Medical, Prescription, HRA, Dental and Vision coverage ends the last day of the month in which you are no longer eligible for benefits. For the Healthcare FSA, and Dependent Care FSA please refer to FSA pages in this guide. For Life/ ADD and Disability benefits your coverage ends the day your last day of employment.

MAKING CHANGES

Any changes you make to your medical plan choices during open enrollment will be effective for the plan period January 1 through December 31, unless you have a change in family status (a qualifying event). Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a change in family status in order to make changes during the year. Qualifying events include:

- Marriage or divorce.
- Birth, adoption or custody change of an eligible dependent.
- A domestic partner becoming a spouse (marriage). Once enrolled as a spouse, imputed income is no longer applicable.
- The loss of coverage due to the death of a spouse or registered domestic partner.
- Loss or gain of coverage due to a spouse's or registered domestic partner's change in employment.
- Unpaid leave of absence by you, your spouse or registered domestic partner.
- A change in employment (either yours, your spouse's or registered domestic partner's) from part-time to full-time or full-time to part-time.
- An increase in the cost of health care coverage for you or your spouse or registered domestic partner because of your spouse's or registered domestic partner's employment.
- An increase in the cost of, or reduction in your Academy of Art University health care benefits.
- Becoming eligible for or losing coverage under a Medicaid or State plan (i.e., MediCal).

If you have a qualifying event at a time other than open enrollment, please contact the ArtU Benefits Team: **benefits@academyart.edu** for IRS permitted qualifying-event review.

Remember that newly eligible dependents, including newborns, spouses and registered domestic partners, can only be added to your plans within 30 days of the date of the Qualifying Life Event. Benefit changes will be effective on the first of the following month.

Questions about Annual Enrollment Process in Workday? Contact the ArtU Benefits Team: **benefits@academyart.edu**.

HMO Medical Plan Choices

The Academy of Art University offers three HMO plan options: **Anthem Select HMO, Anthem CaliforniaCare HMO, and Kaiser HMO**. If you enroll in the **Anthem Select HMO or the Anthem CaliforniaCare HMO**, you must select a Primary Care Physician (PCP) by calling Anthem Select HMO at **(833) 913-2236** or visiting **anthem.com**. Your PCP will provide routine services and refer you to other providers within the Anthem network when needed.

If you enroll in the **Kaiser HMO** you must select a Primary Care Physician by registering on **kp.org** or you can call member services at **(800) 464-4000**. If you don't select a PCP during enrollment, Kaiser may assign one to you.

Please review the plan details carefully to determine which option best meets your needs.

KEY FEATURES	ANTHEM SELECT HMO (CALIFORNIA ONLY)	ANTHEM CALIFORNIACARE HMO (CALIFORNIA ONLY)	KAISER HMO (CALIFORNIA ONLY)
Annual Deductible	$3,000 Individual / $6,000 Family	$3,000 Individual / $6,000 Family	$3,500 Individual / $7,000 Family
Out-of-Pocket Maximum	$5,000 Individual / $10,000 Family	$5,000 Individual / $10,000 Family	$6,500 Individual / $13,000 Family
HRA Deductible Reimbursement	EE Only: $1,500 EE + Dependent(s): $3,000	EE Only: $1,500 EE + Dependent(s): $3,000	EE Only: $1,500 EE + Dependent(s): $3,000
PHYSICIAN SERVICES			
Office Visit	$40 copay	$40 copay	$40 copay
Specialist Office Visit	$60 copay	$60 copay	$50 copay
Virtual Care/Telehealth*	No charge	No charge	No charge
Urgent Care	$40 copay	$40 copay	$40 copay; deductible does not apply
Routine X-Ray & Lab	Diagnostic: No charge Imaging (CT/PET/MRI): $125/day	Diagnostic: No charge Imaging (CT/PET/MRI): $125/day	Diagnostic: $15/encounter after deductible Imaging (CT/PET/MRI): 30% up to $150/procedure after deductible
Chiropractic & Acupuncture	$40 copay; manipulation therapy limited to 20 visits per benefit period and acupuncture limited to 20 visits per benefit period.	$40 copay; manipulation therapy limited to 20 visits per benefit period and acupuncture limited to 20 visits per benefit period.	Not covered
PREVENTIVE CARE			
Routine Preventive Exam	No charge	No charge	No charge
Well-Woman Exam	No charge	No charge	No charge
Well-Child Exam	No charge	No charge	No charge
HOSPITAL SERVICES			
Hospitalization	25% after deductible	25% after deductible	30% after deductible
Outpatient	25% after deductible	25% after deductible	30% after deductible
Emergency Room	$200 copay per visit plus 25% coinsurance after medical deductible; copay waived if admitted. Ambulance: $150 per trip; deductible does not apply.	$200 copay per visit plus 25% coinsurance after medical deductible; copay waived if admitted. Ambulance: $150 per trip; deductible does not apply.	30% after deductible Transport: 30% up to $150 per trip, after deductible
MENTAL HEALTH & SUBSTANCE ABUSE			
Outpatient	$40 copay	$40 copay	$40 copay; deductible does not apply Group visit: $5 copay
Inpatient	25% after deductible	25% after deductible	30% after deductible
PRESCRIPTION DRUGS			
Prescriptions (Retail 30-day) Plan deductible does not apply	Tier 1 (Lower Cost Generic): $5 copay Tier 1b (Generic): $20 copay Tier 2 (Branded): $50 copay Tier 3 (Non-Preferred Branded): $75 copay Tier 4 (Specialty): 30% coinsurance up to $250/RX	Tier 1 (Lower Cost Generic): $5 copay Tier 1b (Generic): $20 copay Tier 2 (Branded): $50 copay Tier 3 (Non-Preferred Branded): $75 copay Tier 4 (Specialty): 30% coinsurance up to $250/RX	Tier 1 (Generic): $15 copay (up to 30-day supply) Tier 2 (Brand Name): $30 copay Tier 4 (Specialty): 20% coinsurance, not to exceed $250, for up to a 30-day supply
Mail Order Prescriptions (90-day)	Tier 1 (Lower Cost Generic): $10 copay Tier 1b (Generic): $40 copay Tier 2 (Branded): $125 copay Tier 3 (Non-Preferred Branded): $188 copay Tier 4 (Specialty): 30% up to $250/RX	Tier 1 (Lower Cost Generic): $10 copay Tier 1b (Generic): $40 copay Tier 2 (Branded): $125 copay Tier 3 (Non-Preferred Branded): $188 copay Tier 4 (Specialty): 30% up to $250/prescription	Tier 1 (Generic): $30 copay (up to 100-day supply) Tier 2 (Brand Name): $60 copay

Virtual/Telehealth: **Anthem: Virtual Care-Only PCP, urgent/acute care, and mental health/substance use services through Anthem's app or website: No charge; virtual specialist care: $60 copay. Other virtual visits follow the applicable office-visit cost share. **Kaiser:** Primary care and specialist telehealth visits by interactive video or telephone are provided at no charge; the plan deductible does not apply.*

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

HMO Medical Plan Choices

The Academy of Art University offers a HMO plan for Hawaii employees — **HMSA HMO**. This Plan uses the HMSA HMO network.

If you enroll in the **HMSA HMO**, you must select a Primary Care Physician (PCP) by calling HMSA at **(866) 939-6013** or visiting **hmsaonlinecare.com/loginConsumer.htm**. Your PCP will provide routine services and refer you to other providers within the HMSA network when needed.

KEY FEATURES	HMSA HMO (HAWAII EMPLOYEES ONLY)
Annual Deductible	None
Out-of-Pocket Maximum	$2,500 Individual/$7,500 Family
PHYSICIAN SERVICES	
Office Visit Copay	$20 copay
Specialist Office Visit Copay	$20 copay
HMSA Online Care	No charge
Urgent Care	$20 copay
Routine X-Ray & Lab	Diagnostic: $10 copay Imaging (CT/PET/MRI): 20%
Chiropractic Services	$40 copay
PREVENTIVE CARE	
Routine Preventive Exam	No charge
Well-Woman Exam	No charge
Well-Child Exam	No charge
HOSPITAL SERVICES	
Hospitalization	10%
Outpatient	10%
Emergency Room	$100 copay / Transport: 20%
MENTAL HEALTH & SUBSTANCE ABUSE	
Outpatient	10%
Inpatient	10%
PRESCRIPTION DRUGS	
Prescriptions (Retail 30-day)	Tier 1 (Generic): $7 copay Tier 2 (Preferred): $30 copay Tier 3 (Non-Preferred): $30 copay, plus $45 tier 3 cost share Tier 4 (Preferred Specialty): $100 copay Tier 5 (Non-Preferred Specialty): $200 copay
Mail Order Prescriptions (90-day)	Tier 1 (Generic): $11 copay Tier 2 (Preferred): $65 copay Tier 3 (Non-Preferred): $65 copay, plus $135 tier 3 cost share Tier 4 (Preferred Specialty): Not covered Tier 5 (Non-Preferred Specialty): Not covered

*The above information is a summary only. Please refer to your Evidence of Coverage for complete details of plan benefits, limitations and exclusions. Find EOCs **here**.*

Health Reimbursement Account (HRA)

At Academy of Art University, we recognize that the cost of health care increases with each passing year. Our goal has always been to offer you the most comprehensive, cost-effective and competitive benefits package possible. Academy of Art University will continue to support our employees expenses by contributing towards your deductibles through a Health Reimbursement Account (HRA) administered by the vendor *HSA Bank*.

Those with the following medical plans will be eligible for deductible reimbursement through the HRA administered by the vendor *HSA Bank*.

- **Kaiser HMO**
  - For **Employee Only** the plan reimburses the first **$1,500** of Deductible expenses
  - For **Employees with Dependents** the plan reimburses the first **$3,000** of deductible expenses
- **Anthem Select HMO & Anthem CaliforniaCare HMO**
  - For **Employee Only** the plan reimburses the first **$1,500** of deductible expenses
  - For **Employees with Dependents** the plan reimburses the first **$3,000** of deductible expenses

HEALTH REIMBURSEMENT ACCOUNT (HRA) – HOW IT WORKS

- **Academy of Art University contributes tax-free money to your account.** These funds will be used to offset your medical plan deductible. These claims are automatically debited from your HRA.
  - With the HRA option, only Academy of Art University contributes to your account.
- **You have 60 days from the date your HRA coverage ends** (e.g., when you switch to the PPO or HSA plan, terminate employment, or drop coverage) to submit claims for deductible-related expenses incurred on or before that date. Expenses incurred after coverage ends are not eligible.
- **Any unused amounts from 2026 do not roll over to be used for eligible expenses incurred in 2027.** Balances reset to $1,500 for employee-only and $3,000 for employee with dependents for both Anthem HMO plans and Kaiser HMO plan.

ARE YOU ELIGIBLE FOR AN HRA?

HRAs are established and funded solely by your employer. The Academy establishes and funds the HRA for eligible HMO enrolled employees.

Employers may only offer an HRA to active employees in combination with an employer-sponsored group health plan.

CONTACT HSA BANK
Phone: (800) 357-6246
Website: hsabank.com
Download HSA Bank Mobile App!
Google Play | App Store

PPO Medical Plan Choices

The Academy of Art University offers a PPO plan for California employees and Out-of-State employees (excluding Hawaii)—**Anthem Prudent Buyer PPO**. This Plan uses a specific network of Health Care Providers called the Prudent Buyer PPO. You pay less for covered services when you use a Participating Provider than a Non-Participating Provider. Providers in this network are called Participating Providers. You can find Participating Providers in this network at **anthem.com** or call **(800) 888-8288**.

HSA Eligibility Note: Enrollment in the PPO plan and eligibility to contribute to a Health Savings Account (HSA) are separate considerations. While this PPO plan may be HSA-qualified, you must also meet IRS eligibility requirements to make or receive HSA contributions.

HSA Eligibility Responsibilities: If you enroll in the HSA-qualified PPO plan, you must notify Human Resources promptly if you become ineligible to make HSA contributions. This may include enrolling in Medicare or TRICARE, gaining other non-HDHP medical coverage, or experiencing another change that affects your HSA eligibility.

KEY FEATURES	ANTHEM PRUDENT BUYER PPO	
	In-network	Out-of-Network
Annual Deductible	$4,000 Individual / $8,000 Family	$12,000 Individual / $24,000 Family
Out-of-Pocket Maximum	$7,000 Individual / $14,000 Family	$21,000 Individual / $42,000 Family
PHYSICIAN SERVICES		
Office Visit	20% coinsurance after deductible	50% coinsurance after deductible
Specialist Office Visit	20% coinsurance after deductible	50% coinsurance after deductible
Virtual Care**	20%	50%
Urgent Care	20%*	50%*
Routine X-Ray & Lab	20%*	50%*
PREVENTIVE CARE		
Routine Preventive Exam	No charge	50%
Well-Woman Exam	No charge	50%
Well-Child Exam	No charge	50%
HOSPITAL SERVICES		
Hospitalization	20%*	50%*
Outpatient	20%*	50%*
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible
MENTAL HEALTH & SUBSTANCE ABUSE		
Outpatient	20% coinsurance after deductible*	50%*
Inpatient	20%*	50%*
PRESCRIPTION DRUGS		
Prescriptions (Retail 30-day/90-day)	Tier 1a (Lower Cost Generic): $5 copay after deductible Tier 1b (Generic): $20 copay after deductible Tier 2: (Branded): $40 copay after deductible Tier 3 (Non-Preferred Branded): $60 copay after deductible Tier 4 (Specialty): 30% coinsurance up to $250/prescription after deductible	50% coinsurance up to $250/prescription (Retail Only)
Mail Order Prescriptions (31-90-day)	Tier 1a (Lower Cost Generic): $10 copay after deductible Tier 1b (Generic): $40 copay after deductible Tier 2: (Branded): $100 copay after deductible Tier 3 (Non-Preferred Branded): $150 copay after deductible Tier 4 (Specialty): 30% coinsurance up to $250/prescription after deductible	Not covered

** Unless otherwise stated, all PPO coinsurance amounts shown in this table apply after the deductible.*
***Virtual Care-Only providers through Anthem's app or website: No charge for PCP, urgent/acute care, and mental health/substance use services; specialist care: 20% after deductible. Other virtual visits: 20% after deductible in network / 50% after deductible out of network.*

*The above information is a summary only. Please refer to your Evidence of Coverage for complete details of plan benefits, limitations and exclusions. Find EOCs **here**.*

Health Savings Account (HSA)

Employees enrolled in the Anthem Prudent Buyer PPO Plan—available to California and out-of-state employees (excluding Hawaii)—may be eligible to open and contribute to a Health Savings Account (HSA). An HSA provides a tax-advantaged way to save and pay for eligible health care expenses, including deductibles, copays, coinsurance, prescriptions, dental care, and vision expenses. Contributions are generally made pre-tax, earnings grow tax-free, and withdrawals for eligible expenses are tax-free. Funds roll over year to year and remain with the employee, even if employment or health plan coverage changes.

For 2027, ArtU will not make employer HSA contributions. Employees with self-only HSA-eligible coverage may contribute up to $4,500, while those with family coverage may contribute up to $9,000. Employees age 55 or older may make an additional $1,000 catch-up contribution. Employees must meet IRS eligibility requirements to contribute.

HSA Eligibility Responsibilities: If you enroll in the HSA-qualified PPO plan, you must notify Human Resources promptly if you become ineligible to make HSA contributions. This may include enrolling in Medicare or TRICARE, gaining other non-HDHP medical coverage, or experiencing another change that affects your HSA eligibility.

CONTRIBUTE TO YOUR HSA

Contributing to your HSA is easy and convenient. HSA Bank provides multiple ways for you to contribute to your account.

- **Payroll Deductions.** If you enroll in an Anthem PPO medical plan, you can make pre-tax contributions to your HSA from your paycheck.
- **Online Transfers.** You can contribute to your account through the HSA Bank Member Website.
- **Transfers or Rollovers.** Once your HSA account is opened, IRS regulations permit the transfer or rollover of funds to an HSA from an existing HSA or MSA (Medical Savings Account). To learn more about consolidating your HSAs or transferring funds, visit **hsabank.com/transfer**.
- **Termination or end of employment.** Your Health Savings Account is entirely yours. We recommend that you update your HSA email address to your personal one. Download the HSA Bank app and make sure to sign up for electronic preferences.

PAY FOR IRS-QUALIFIED EXPENSES WITH YOUR HSA

It's easy to pay for IRS-qualified medical expenses with an HSA. HSA Bank offers several convenient options to pay for current or future healthcare expenses, which include deductibles, coinsurance, prescriptions, vision, dental care, and more.

An HSA is a unique tax-advantaged account that can be used for current or future healthcare expenses. To pay for a service or make a purchase, funds need to be available in your HSA account.

- **Use Your Health Benefits Card** – The HSA Bank Health Benefits Debit Card provides access to your HSA funds at point-of-sale with signature or PIN. HSA Bank limits point-of-sale debit card transactions to medical merchants. Debit card transactions are limited to your current balance.
- **Pay Online** – You can pay a provider directly from your HSA on the Member Website or mobile app.

REIMBURSE YOURSELF FOR OUT-OF-POCKET MEDICAL EXPENSES

You can pay yourself back from your HSA for IRS-qualified medical expenses that were paid out of pocket. There are multiple options for accessing your funds.

- **HSA Bank Health Benefits Debit Card**. *You can use your HSA Bank Health Benefits Debit Card at an ATM to reimburse yourself for eligible expenses paid out-of-pocket (a transaction fee may apply).*

  Note: When withdrawing HSA funds from an ATM, be sure to select the "checking" option (not savings) when asked the type of account you are withdrawing from.

- **Online Transfer.** On HSA Bank's Member Website, you can transfer funds from your HSA to an external bank account, such as a personal checking or savings account. There is a daily transfer limit of $2,500 to safeguard against fraudulent activity.

Note: You will be able to reimburse yourself for IRS-qualified medical expenses that you incur from the establishment date of your HSA. For example, if your HSA establishment date is January 1, you can reimburse yourself for expenses incurred on or after that date.

CONTACT HSA BANK

Phone: (800) 357-6246 **Fax:** (877) 851-7041
Website: hsabank.com

Mailing Address for Claims:
P.O. Box 2744, Fargo ND 58108-2744

Download HSA Bank Mobile App!
Google Play | App Store

Dental Plans

Academy of Art University offers employees the choice of two dental plans through Anthem. With either plan, you are not required to choose a PPO network dentist. If you do choose a PPO network dentist, you will have lower out-of-pocket costs because Anthem negotiates lower fees with network dentists and passes the savings along to you. Participants using out-of-network dentists may be responsible for charges exceeding Anthem's reimbursement amounts, in addition to their coinsurance. You can find a list of participating dentists at **anthem.com** or call **(844) 729-1565**.

The coinsurance percentages represent your financial responsibility.

ANTHEM DENTAL PPO*				
	BASE PLAN		BUY-UP PLAN	
	IN-NETWORK DENTISTS	NON-NETWORK DENTISTS		
Calendar Year Deductible	$50 **Individual** $150 **Family** Waived for Preventive Care		$50 **Individual** $150 **Family** Waived for Preventive Care	
Calendar Year Maximum	$1,000 Individual		$1,500 Individual	
Preventive & Diagnostic Services (Limit 2 cleanings per year)	No charge*	20%	No charge*	
Basic Services (Fillings, extractions, periodontics, etc.)	20%	40%	20%	20%
Major Services *(Crowns, bridges, dentures, etc.)*	50%	50%	50%	50%
Orthodontics	50% deductible does not apply Adults & Dependent Children Lifetime Maximum: $1,000 Coverage has no age restrictions or waiting periods.		50% deductible does not apply Adults & Dependent Children Lifetime Maximum: $1,500 Coverage has no age restrictions or waiting periods.	

* The benefits paid by Anthem of California to your dentist for preventive care are applied to your calendar year maximum even if you owe nothing. You will be responsible for the cost of preventive & diagnostic services if you have already exhausted your maximum benefit for the year at the time of service.

THE BELOW PLAN IS FOR HAWAII EMPLOYEES ONLY

You can find a list of participating dentists at **https://hmsadental.com/find-a-dentist** or call **(800) 776-4672**.

The coinsurance percentages represent your financial responsibility.

HMSA DENTAL	
	IN-NETWORK DENTISTS
Calendar Year Maximum	$1,500
Calendar Year Rollover	up to $500 (Max accumulation $1,250)
Preventive & Diagnostic Services *(limit 2 cleanings per year)*	No charge
Basic Services *(Fillings, extractions, periodontics, etc.)*	30%
Major Services *(Crowns, bridges, dentures, etc.)*	50% (12 month waiting period)
Orthodontics	Not covered

Vision Plan

Academy of Art University offers you vision care coverage through Anthem Blue View Vision. With Anthem Blue View Vision, you can receive vision care services from any provider you choose. However, you will receive the highest level of coverage when you use network providers. Most eligible services accessed from network providers are covered at 100% up to the plan's allowance for a specific service. Vision care accessed from out-of-network providers is covered at lower levels. You can find a list of participating providers by visiting **anthem.com** or call **(866) 723-0515**

The copays represent your financial responsibility.

ANTHEM VISION		
BENEFIT FREQUENCY	**IN-NETWORK**	**OUT-OF-NETWORK**
Examination	Once per calendar year	
Lenses	Once per calendar year	
Frames	Once per calendar year	
Contacts *(In lieu of lenses and frames)*	Once per calendar year	
PLAN PROVISIONS	**IN-NETWORK**	**OUT-OF-NETWORK**
Examination	$20 copay	Reimbursed up to $42
Eyeglass Lenses* • **Eyeglass Lens Enhancements:** – Transitions Lenses – Standard Polycarbonate – Factory Scratch Coating	All Lens Types: $20 copay Transitions: $0 for children under 19; $75 adult upgrade Standard polycarbonate: $0 for children under 19; $40 adult upgrade Factory scratch coating: $0 for all members	Single Vision: Up to $40; Bifocal: Up to $60; Trifocal: Up to $80
Frames	$130 allowance, then 20% off any remaining balance	Reimbursed up to $45
Contact lenses • Elective (Instead of Eyeglasses) • Non-Elective (Medically Necessary)	Elective Conventional: $130 allowance, then 15% off any remaining balance Elective Disposable: $130 allowance (no additional discount) Non-Elective: Covered in full	Elective Conventional and Disposable: Reimbursed up to $105 Non-Elective: Reimbursed up to $210
Retinal Screening	Not more than $39	Additional cost not covered

** Out-of-network reimbursements apply to standard prescription lenses only. Lens enhancements are not reimbursed when obtained out-of-network.*

THE BELOW PLAN IS FOR HAWAII EMPLOYEES ONLY

You can find a list of participating providers at **https://eyedoclocator.eyemedvisioncare.com/hmsa/en** or call **(800) 776-4672**.

The coinsurance percentages represent your financial responsibility.

HMSA VISION		
BENEFIT FREQUENCY	**ADULT**	**CHILD**
Examination	Once per calendar year	
Lenses	Once per calendar year	
Frames	Once per calendar year	
Contacts *(In lieu of lenses and frames)*	Once per calendar year	
PLAN PROVISIONS	**ADULT**	**CHILD**
Examination	No Charge	No Charge
Eyeglasses *(lenses & frames)*	$25 copay	$25 copay
Contact lenses	Up to $110 allowance	Up to $110 allowance
Polycarbonate Lenses	Not Covered	No Charge
One Eyeglass Frame *(one every other calendar year)*	Covered up to $130 copay	Up to $85
Additional benefits		
Contact Lens Fitting	Not Covered	Not Covered

Your Monthly Contributions

	EMPLOYEE ONLY	EMPLOYEE + SPOUSE/DP*	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY*
KAISER HMO (CALIFORNIA EMPLOYEES)	$75.67	$416.82	$361.82	$781.95
ANTHEM SELECT HMO (CALIFORNIA EMPLOYEES)	$91.98	$415.37	$404.57	$863.99
ANTHEM CALIFORNIACARE HMO (CALIFORNIA EMPLOYEES)	$184.69	$1,176.21	$734.89	$1,838.19
ANTHEM PRUDENT BUYER PPO (CALIFORNIA EMPLOYEES)	$208.39	$512.87	$499.54	$1,066.81
ANTHEM PRUDENT BUYER PPO (OUT-OF-STATE EMPLOYEES)	$164.52	$512.87	$499.54	$1,066.81
ANTHEM BASE DENTAL PLAN	$30.28	$75.90	$70.62	$114.97
ANTHEM BUY-UP DENTAL PLAN	$42.65	$102.24	$95.34	$153.28
ANTHEM BLUE VIEW VISION	$3.61	$7.22	$7.94	$12.75

*If you are covering a Domestic Partner and or a child of your Domestic Partner, premiums for coverage are paid with after-tax deductions and imputed income.

HMSA EMPLOYEE PLAN COST (HAWAII EMPLOYEES ONLY)

Plan year runs July 1, 2026 through June 30, 2027. Rates include cost for HMSA HMO, dental and vision plans.

	EMPLOYEE ONLY	EMPLOYEE + DEPENDENT/DP*	EMPLOYEE + 2 OR MORE DEPENDENTS
HMSA HMO (HAWAII EMPLOYEES ONLY)	$119.31	$1,295.40	$2,069.38



FSA, HRA and HSA Comparison

ACCOUNT TYPE	HEALTHCARE FLEXIBLE SPENDING ACCOUNT (HEALTHCARE FSA)	HEALTH REIMBURSEMENT ACCOUNT (HRA)	HEALTH SAVINGS ACCOUNT (HSA)
Description	Employee funded account used to cover eligible medical expenses.	Employer funded account to reimburse employees for eligible medical expenses.	Savings account established for the purpose of paying current or future medical expenses.
Account Ownership	Employer	Employer	Individual/Employee
Who Can Open the Account?	Employers on behalf of its employees.	Employers on behalf of its employees.	Any individual that meets the eligibility requirements. This does not have to be an employment-based account.
Who Can Contribute to the Account?	Employee	Employer (Employee contributions are not permitted.)	Contributions can be made by the account holder.
Who is Eligible?	Current employees (coverage may also be elected to cover spouse and dependents).	Current employees (coverage may also be elected to cover spouse and dependents).	1. Must be covered by a qualified high deductible health plan (HDHP). 2. Must not be covered by any other plan that is not a qualified HDHP. 3. Must not be enrolled in Medicare or Tricare. 4. Must not be claimed as a dependent on another person's tax return. 5. If you have questions about your eligibility for the HSA please contact Human Resources. HSA Eligibility Responsibilities: If you enroll in the HSA-qualified PPO plan, you must notify Human Resources promptly if you become ineligible to make HSA contributions. This may include enrolling in Medicare or TRICARE, gaining other non-HDHP medical coverage, or experiencing another change that affects your HSA eligibility.
Who is Not Eligible?	Participants in an HSA cannot contribute to a Healthcare FSA.	Participants either in the PPO or HSA medical plans.	Contributions cannot be made or received by anyone that fails to meet the criteria for eligibility, but funds already in the account can be withdrawn tax-free by the account holder and/or their spouse/dependents for qualified medical expenses. If a child is still a tax-dependent (up to age 19 or, if full-time student, age 24), then the child's out-of-pocket medical expenses can be paid with your HSA. Your child can still be covered under the medical plan up to age 26 though regardless of student status.
Must the Account be Paired with a Health Plan?	Employer must offer a health plan to employees to meet the definition of an Excepted Benefit. You cannot participate in the medical FSA if you select the PPO plans.	You cannot participate in the medical FSA if you select the PPO plans.	Contributions can only be made while enrolled in a qualified HDHP.
Tax Advantages (Individual)	1. Pre-tax contributions via salary reduction. 2. Reimbursements are tax-free.	Reimbursements are tax-free.	1. Pre-tax/Tax-deductible contributions. 2. Tax-deferred growth. 3. Tax-free distributions for qualified medical expenses.
2027 Annual Contribution Limits*	The limit is $3,500 for employee salary reductions.	Anthem & Kaiser: $1,500 for Employee-Only or $3,000 for Employees with Dependents.	$4,500 Employee-Only or $9,000 for Employees with Dependents. $1,000 catch-up contribution for people age 55 and older.
Do Funds Roll Over?	No Rollover.	No Rollover.	HSA 100% rolls over.
Eligible Expenses	Reimbursement of any expense defined by IRS Code Section 213(d).	Reimbursement of HMO Plan deductible expenses, defined by IRS Code Section 213(d).	Defined by IRS Code Section 213(d). Reference IRS Publication 502 for a partial list of qualified expenses.
Non-Eligible Expenses	Funds cannot be used for ineligible expenses.	Funds cannot be used for ineligible expenses.	Subject to income taxes and a 20% penalty for people under age 65. Only subject to income taxes if over age 65.
Subject to COBRA	Circumstances vary.	Yes.	No, but accounts are portable.

**Limits subject to change pending final 2027 IRS notice.*

Flexible Spending Accounts (FSA)

If you know you are going to incur out-of-pocket expenses for healthcare and/or dependent daycare (childcare and/or eldercare) during the year, you may want to enroll in one or both of the Flexible Spending Account plan options.

There are two types of FSAs:

1. **The Health Care FSA** is used to pay for your out-of-pocket health care expenses for you and your eligible dependents
2. **The Dependent Care FSA** is used to pay for eligible day-care expenses for children or dependent elders.

HERE IS HOW THE ACCOUNTS WORK:

- You decide how much to contribute:
  - Up to $3,500** a year in the Health Care FSA*
  - Up to $7,500 a year in the Dependent Care FSA*
  - A minimum annual contribution of $240 is required to enroll in the Health Care FSA or Dependent Care FSA.
- The amount you decide to contribute is deducted from your pay in equal installments through the plan year.
- You pay no federal income tax or FICA taxes on your contributions.
- When you have an eligible expense, you may either use your HSA Bank Debit Card, which also acts as a credit card, to pay for the expense or submit a claim with a receipt of payment through the HSA Bank Member website, **hsabank.com**.

** Any contributions you have made with a previous employer in 2027 do not count toward the annual maximum*

HEALTH CARE FSA (HCFSA)

You can contribute up to $3,500** per year to the Health Care Spending Account to pay for eligible out-of-pocket health care expenses for you and your eligible family members even if you are not covered under Academy of Art University health plans.

The HSA Bank debit card is an additional convenience that allows you immediate access to your FSA funds. Simply swipe your card at your doctor's office or participating retailer. When using your HSA Bank debit card make a habit of saving all of your itemized receipts. IRS regulations require you to retain all itemized receipts for purchases made with the card. If HSA Bank requests documentation to verify your eligibility and you do not provide it, the IRS may treat contributions as excess contributions which may result in tax penalties and the requirement to withdraw the excess amount. You are responsible for any applicable taxes and penalties.

Eligible out-of-pocket expenses include:

- Deductibles, copays and coinsurance amounts for medical, dental, and vision expenses
- Eyeglasses, contact lenses, and prescription sunglasses not covered by the vision plan
- Orthodontia expenses not covered by a dental plan
- Some physician-prescribed weight-loss programs
- Expenses not covered by Academy of Art University medical plans but considered eligible by the IRS.

***Limits subject to change pending final 2027 IRS notice.*

Flexible Spending Accounts (FSA) (continued)

DEPENDENT CARE SPENDING ACCOUNT (DCFSA)

You can contribute up to $7,500 a year to the Dependent Care FSA to pay for eligible child or elder care expenses required so that you (or you and your spouse if you are married) can work outside your home. Your spouse must be working or attending school full-time to qualify for Dependent Care Expenses. See the chart below for contribution limits.

Eligible expenses include:

- Baby-sitting and day care
- Before and after-school care
- Elder care
- Preschool and nursery school
- Family day care
- Summer day camp

You may be required to submit evidence that an expense is a qualifying dependent care expense if required by your FSA Administrator, HSA Bank. Ineligible dependent care expenses include private school tuition, placement fees (for getting a baby-sitter), transportation costs, and registration fees. The full list of eligible dependent care expenses is available at **http://www.irs.gov/publications/p503**.

It is recommended that you consult with your tax advisor to determine whether the federal child care tax credit may be more beneficial than participation in the Dependent Care FSA.

AMOUNT YOU CAN CONTRIBUTE TO THE DEPENDENT CARE FSA

IF YOU ARE:	YOU CAN CONTRIBUTE UP TO:
Single	$7,500
Married, file a joint tax return, and your spouse isn't eligible to contribute to a Dependent Care FSA	$7,500
Married, file a joint tax return, and your spouse is eligible to contribute to a Dependent Care FSA	$7,500 (you and your spouse combined)
Married, and either you or your spouse earns less than $5,000 per year	Any amount up to the lower of your or your spouse's annual earnings
Married and file a separate tax return	$3,750
Married and your spouse is disabled or a full-time student	$3,400 for one dependent or $6,800 for two or more Dependents

TAX SAVINGS

FSAs help reduce your taxes. You don't pay federal income tax or FICA taxes on your contributions. Your tax savings depend on the amount you decide to contribute and your tax bracket (the percentage of income you pay in federal income tax).

The savings if you are in a 15, 25, or 35 percent federal income tax bracket (see chart below). Your savings will be greater if you are in a higher tax bracket.

	TAX SAVINGS FOR THE FOLLOWING TAX BRACKETS		
Amount You Contribute	**15%**	**25%**	**35%**
$240	$54	$78	$84
$500	$113	$163	$175
$1,000	$226	$326	$350
$1,500	$340	$490	$525
$2,000	$453	$653	$700
$5,000	$1,135	$1,632	$1,750

Flexible Spending Accounts (FSA) (continued)

EXPENSES NOT ELIGIBLE

Expenses not eligible for the Health Care FSA include services that the IRS does not allow as federal income tax deductions, including cosmetic surgery, massage therapy, and supplements, such as vitamins that can be purchased over the counter as well as all other over-the-counter medications unless you have a doctor's prescription. The full list of eligible health care expenses is available at **http://www.irs.gov/publications/p502** or at **https://fsastore.com/FSA-Eligibility-List.aspx**.

FSA STORE

As an additional resource, you can visit the FSA Store at **https://fsastore.com/** to use your flexible spending account to buy eligible products. Many products have a discount and shipping is free for orders which are $50 or more.

USE IT OR LOSE IT

Plan your expenses carefully. You forfeit any unused balances. You will have until March 1, 2028 to submit claims for expenses incurred in the current plan year (ends December 31). You can obtain claim forms from HSA Bank. Please refer to the contact information section.

FLEXIBLE SPENDING ACCOUNT (FSA) RULES

These rules apply to both the Health Care FSA and Dependent Care FSA.

1. Expenses must be incurred during the plan year which takes place January 1 through December 31. There are exceptions if you terminate your employment with Academy of Art University mid-year. See the next section for details.
2. Claims can be filed until March 1, 2028 for reimbursement (see the next section for additional information should you terminate your employment mid-year).
3. You may enroll in one or both accounts. However, the accounts are separate. You may not use funds from your Health Care FSA to pay for dependent care expenses and vice versa.
4. You must designate how much money you wish to contribute annually to each account at the beginning of the Plan Year.
5. You may change your annual contributions only if you experience a qualifying "change in family status," such as marriage, divorce, addition or loss of a dependent, or a change in your spouse's employment.
6. It is important to carefully review your estimated expenses, since any unused funds remaining in each account at the end of the plan year must be forfeited—referred to as the "Use It or Lose It Rule."
7. Items paid through the FSA cannot be claimed on your income taxes.
8. You must re-enroll each plan year. Your elections will not carry over from year to year.

FLEXIBLE SPENDING ACCOUNT RULES WHEN YOU TERMINATE YOUR EMPLOYMENT MID-YEAR

1. Your expenses must be incurred during the period of the plan year in which you are an active Academy of Art University employee (from January 1 until the date you terminate your employment). Once you terminate your employment, you can only submit a claim incurred after the date your employment terminates by electing COBRA and contributing to your FSA on an after-tax basis. Dependent Care FSA's cannot be continued after your employment termination date.
2. Claims incurred prior to the date your employment terminated must be filed for reimbursement within 60 days of your date of termination.

DIRECT DEPOSIT THROUGH HSA BANK

Your FSA claims reimbursements can be deposited directly into your bank account. To sign up for Direct Deposit, login to the participant portal on **hsabank.com**.

CONTACT HSA BANK

Phone: (800) 357-6246 **Fax:** (877) 851-7041

Website: hsabank.com

Mailing Address for Claims:
P.O. Box 2744, Fargo ND 58108-2744

Download HSA Bank Mobile App!

Google Play | App Store

Commuter Program

The Academy of Art University Commuter Program is administered by Edenred. By participating in this program, you can set aside pre-tax dollars to pay for the transit and parking costs associated with your commute to and from work. The transit portion of the Edenred program allows you to set aside pre-tax contributions to pay for bus passes, transit passes and/or Edenred vouchers. You may choose to have a re-loadable Smart Card, a re-loadable Edenred Prepaid MasterCard, a pass or commuter funds deposited directly onto a valid commuter transit card. If a physical pass is ordered, it will be delivered to your home.

The parking portion of the Commuter Program allows you to set aside pre-tax contributions to pay for commuter parking expenses. You may choose to place orders for one of the following options: send automated monthly payments electronically directly to the parking vendor (Monthly Direct Pay), a re-loadable Edenred Prepaid MasterCard, Commuter Check for Parking Vouchers, or a Parking Cash Reimbursement.

You may deduct pre-tax money from your paycheck to pay for commute-related expenses which reduces your taxable income. The maximum contribution is:

- Transit: $350 monthly*
- Parking: $350 monthly*

Parking Reimbursement Orders: Edenred Orders are placed two months in advance, so a March order must be submitted in January before the deadline. Click **here** for helpful tips for your Parking Reimbursement Orders.

HOW TO ENROLL OR MAKE CHANGES

To enroll or make changes, please register by visiting **login.edenredbenefits.com/**. From the landing page, select “Setup My Account” from the Employee Login area. To register you will need Academy of Art University’s Company ID (1539), your first and last name and your home zip code. Note, the name you use must match what is in Academy of Art University’s system (example, if you are in the Academy’s system as “James”, you must use that name when registering vs. “Jim”).

If you are no longer working for the Academy, you have until the 25th of the month in which your employment terminates to use all available funds. Example: If employment ends April 22, you must place order by April 25 (the ordering deadline for that period) to use your remaining funds. Any unused balance after the ordering deadline will be forfeited.

**Limits subject to change pending final 2027 IRS notice.*



Voluntary Supplemental Health Plans

NEW FOR 2027 | VOLUNTARY SUPPLEMENTAL HEALTH BENEFITS

Extra financial support when life takes an unexpected turn

Medical insurance helps pay for covered care. Anthem Voluntary Supplemental Health Benefits can provide an added layer of financial protection by paying cash benefits directly to you after a covered event. Use the money in the way that helps most—whether for medical expenses, a deductible, rent, groceries, transportation, child care, or time away from work.

These voluntary plans complement your medical coverage; they do not replace it.

ACCIDENT INSURANCE

Extra protection after an unexpected injury

Accident Insurance provides cash benefits after a covered **off-the-job accident** and related care.

Benefits can help with:

- Emergency treatment and follow-up care
- Fractures and dislocations
- Specified injuries and surgeries
- Hospital and ICU confinement
- Catastrophic injuries and accidental death and dismemberment
- Covered organized sports injuries

A practical way to help protect your budget when an injury leads to unplanned care and everyday expenses.

CRITICAL ILLNESS INSURANCE

Support when a serious diagnosis changes everything

Critical Illness Insurance provides a **lump-sum cash benefit** after a qualifying diagnosis. Available benefit amounts are $10,000, $20,000, or $30,000 for employees, with dependent coverage available.

Covered conditions include:

- Invasive and noninvasive cancer; benign brain tumor
- Heart attack, stroke, heart failure, and coronary artery disease
- Major organ failure, end-stage renal disease, coma, and paralysis
- Loss of hearing, speech, or vision
- Advanced Alzheimer's disease, advanced Parkinson's disease, ALS, and advanced multiple sclerosis

One less financial concern when your focus needs to be on treatment and recovery.

HOSPITAL INDEMNITY INSURANCE

Cash support for a covered hospital stay

Hospital Indemnity Insurance pays cash benefits for a covered inpatient hospital admission and each day of confinement due to illness or injury.

Plan features include:

- An optional daily ICU confinement benefit
- Coverage for hospitalizations due to pregnancy, with no maternity waiting period
- Newborn confinement coverage after childbirth
- No pre-existing condition limitation

Helpful protection for expenses medical coverage may not fully address—and for the practical costs that continue while you are hospitalized.

HOSPITAL INDEMNITY AT-A-GLANCE

Plan level	First-day hospital benefit*	Daily hospital benefit*	Daily ICU benefit*
Low	$500	$100	$200 with ICU option

*The first-day benefit is payable once per year. Daily hospital confinement and, when elected, ICU confinement benefits are payable for up to 31 days per year, subject to plan terms.

MORE VALUE BUILT INTO EVERY PLAN

- **Benefits are paid directly to you.** There is no requirement to use the payment only for medical bills.
- **Eligible dependents can be covered**, helping extend protection to your spouse and children.
- **Health screening benefit:** Each of the three Voluntary Supplemental Health Plans—Accident Insurance, Critical Illness Insurance, and Hospital Indemnity Insurance—includes a $50 annual Health Screening Benefit for each covered member who completes an eligible preventive screening. The benefit is available separately under each enrolled plan. Covered members enrolled in all three plans may receive up to $150 annually in Health Screening Benefits ($50 per plan), subject to applicable plan provisions.
- **Anthem-connected claim support:** If you are enrolled in both Anthem medical and Anthem supplemental health coverage, the Sydney Health app may notify you when Anthem identifies a potential eligible claim. You must still submit the claim.

These voluntary, limited-benefit insurance plans are not major medical coverage and do not replace your medical plan. Benefits are paid only for covered events and are subject to the group policy, certificate, exclusions, limitations, and applicable terms. Refer to your enrollment materials and certificate of coverage for complete details and instructions on how to file a claim.

Voluntary Supplemental Health Plans—Monthly Rate

Accident Insurance

Coverage Tier	Medium Plan
Employee	$6.56
Employee + Spouse	$10.46
Employee + Child(ren)	$10.98
Employee + Family	$17.32

Hospital Indemnity Insurance

Coverage Tier	Low + ICU
Employee	$8.44
Employee + Spouse	$17.44
Employee + Child(ren)	$12.66
Employee + Family	$22.20

Critical Illness Insurance—Monthly Rates by Employee Age

Rates shown below are based on the employee's attained age. EE = Employee | SP = Spouse | CH = Child(ren) | FAM = Family

$10,000 Plan | Spouse $5,000 | Child $5,000				
Age	EE	EE + SP	EE + CH	EE + FAM
18–24	$2.96	$4.82	$4.42	$6.54
25–29	$3.60	$5.78	$5.06	$7.50
30–34	$3.96	$6.36	$5.44	$8.06
35–39	$4.96	$7.84	$6.42	$9.54
40–44	$6.82	$10.74	$8.30	$12.46
45–49	$10.50	$16.52	$11.98	$18.24
50–54	$14.36	$22.60	$15.82	$24.30
55–59	$19.30	$30.46	$20.76	$32.16
60–64	$27.04	$42.66	$28.50	$44.38
65–69	$37.90	$59.40	$39.38	$61.12
70–74	$50.94	$79.58	$52.40	$81.28
75–79	$67.08	$104.46	$68.54	$106.16
80–84	$78.50	$121.92	$79.96	$123.64
$20,000 Plan | Spouse $10,000 | Child $10,000				
Age	EE	EE + SP	EE + CH	EE + FAM
18–24	$5.90	$9.64	$8.84	$13.06
25–29	$7.18	$11.56	$10.12	$14.98
30–34	$7.92	$12.70	$10.86	$16.12
35–39	$9.90	$15.66	$12.84	$19.08
40–44	$13.64	$21.48	$16.58	$24.90
45–49	$21.00	$33.04	$23.94	$36.46
50–54	$28.70	$45.18	$31.64	$48.60
55–59	$38.58	$60.90	$41.52	$64.32
60–64	$54.06	$85.32	$57.00	$88.74
65–69	$75.80	$118.80	$78.74	$122.22
70–74	$101.86	$159.14	$104.80	$162.56
75–79	$134.14	$208.90	$137.08	$212.32
80–84	$156.98	$243.84	$159.92	$247.26
$30,000 Plan | Spouse $15,000 | Child $15,000				
Age	EE	EE + SP	EE + CH	EE + FAM
18–24	$8.86	$14.46	$13.26	$19.60
25–29	$10.78	$17.34	$15.18	$22.48
30–34	$11.88	$19.06	$16.30	$24.18
35–39	$14.86	$23.50	$19.26	$28.62
40–44	$20.46	$32.22	$24.88	$37.36
45–49	$31.50	$49.56	$35.92	$54.70
50–54	$43.06	$67.78	$47.46	$72.90
55–59	$57.88	$91.36	$62.28	$96.48
60–64	$81.10	$127.98	$85.50	$133.12
65–69	$113.70	$178.20	$118.12	$183.34
70–74	$152.80	$238.72	$157.20	$243.84
75–79	$201.22	$313.36	$205.62	$318.48
80–84	$235.48	$365.76	$239.88	$370.90

Life/AD&D Insurance

All full-time employees are eligible for Life/AD&D benefits in addition to Long Term Disability (LTD) Insurance. Part-time employees who work an average of at least 30 hours per week in a one year measurement period are also eligible for benefits.

BASIC LIFE/AD&D

Life insurance coverage provides you and your family with important financial security. Academy of Art University provides an employer-paid Basic Life & AD&D benefit of $15,000. This policy is underwritten by NY Life.

If you should die in an accident, your Accidental Death and Dismemberment (AD&D) policy provides you with an additional benefit equal to your life policy. This benefit is provided to you without evidence of insurability and is paid for by Academy of Art University.

Life/AD&D benefits will reduce by 35% at age 65 and by 50% at age 70.

VOLUNTARY LIFE/AD&D

VOLUNTARY LIFE AND AD&D BENEFIT	
Employee Voluntary Life/AD&D Amount	$10,000 increments up to the lesser of five times annual salary or $300,000. Guaranteed issue is $200,000.
Spouse Voluntary Life/AD&D Amount	$5,000 increments up to the lesser of 50% of employee life amount or $150,000. Guaranteed issue is $30,000.
Child(ren) Voluntary Life/AD&D Amount *(lower coverage prior to 6 months)*	$10,000 for children (up to age 26)

Please note the following election guidelines:

- You can not purchase Life or AD&D for your dependents without enrolling yourself.
- You can elect to enroll in either Voluntary Life or Voluntary AD&D or both.

Once enrolled in the Life Insurance plan, you will have the opportunity during future open enrollments to increase your Life Insurance benefit by up to $20,000 (up to the guarantee issue limit) without needing to complete a medical questionnaire.

However if you waive Life coverage when you are first eligible and later decide to enroll, you will be required to complete a medical questionnaire. In this case, New York Life may decline your application based on medical underwriting if you are deemed uninsurable due to a medical condition.

It's important to note that Voluntary Accidental Death and Dismemberment (AD&D) coverage is not subject to medical underwriting.

Additionally, if you previously enrolled your Spouse/Domestic Partner in Life Insurance, you can increase their Life Insurance benefit by $5,000 during open enrollment without a medical questionnaire, as long as the total coverage remains within the guarantee issue limit.

** If both you and your spouse or Domestic Partner are employees of the Academy of Art University, you may not enroll one another as your dependent under the Voluntary Life and AD&D plan if you are also enrolling as an employee.*

*** Guaranteed issue is the amount of coverage you or your dependent are eligible for without being subject to a medical questionnaire.*

Disability Insurance

All full-time employees are eligible for Disability Insurance. Part-time employees who work an average of at least 30 hours per week in a one year measurement period are also eligible for benefits.

SHORT TERM DISABILITY (STD) (NON-CA EMPLOYEES ONLY)*

Academy of Art University provides an employer-paid Short Term Disability or (STD) coverage which is an income replacement policy and is designed to provide you with a benefit when you are disabled and unable to work because of a covered illness, surgery, or injury.

SHORT TERM DISABILITY (STD)**	
Weekly Benefit Amount*	Plan pays 60% of earnings
Maximum Weekly Benefit	$1,540
Benefits Begin After: Accident Sickness	 7 days of disability 7 days of disability
Maximum Benefit Period*	26 weeks

** Class 1 Active Full-Time Employees of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States, excluding employees working in California.*

*** Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section in your plan documents.*

LONG TERM DISABILITY (LTD)

Academy of Art University provides an employer-paid Long Term Disability or (LTD) coverage which is an income replacement policy and is designed to provide you with a benefit when you are disabled and unable to work.

Disability is defined as your inability to perform the duties of the occupation for which you were trained for the first 24 months and are unable to perform the duties of any occupation after that. Benefits are payable as long as you remain disabled up to your normal retirement age. The LTD program is insured through NY Life.

LONG TERM DISABILITY (LTD)	
Elimination Period	180 days
Percent of Salary	60%
Maximum Benefit	$5,000 Monthly
Maximum Benefit Duration	Social Security normal retirement age.

WHY IS DISABILITY INSURANCE IMPORTANT?

Disability insurance can pay you benefits if you suffer a covered disability. Think of it as insurance for a portion of your paycheck. Payments may come directly to you or someone you designate and can help pay for things like:

- Groceries
- The mortgage
- Utilities
- Medical Bills

Additional Benefits and Perks

TRAVEL ASSISTANCE PROGRAM

The NY Life Secure Travel Program is an added benefit for employees covered under NY Life's Voluntary Life/AD&D or Long Term Disability policies at no cost to you. It gives you 24-hour, toll-free access to emergency assistance when you travel away from home on vacation or business. These benefits and services are also available for your dependents, whether or not they are traveling with you. For easy access in case of an emergency, pick up a service description and keep it with your travel documents or luggage. For a complete description of services as well as detailed contact information for inquiries and claim submissions, call **(888) 226-4567** from the US or Canada, **(202) 331-7635** (collect) from all other locations or email **ops@us.generaliglobalassistance.com**.

EMPLOYEE ASSISTANCE & WELLNESS SUPPORT

New York Life Group Benefit Solutions offers the Employee Assistance & Wellness Support program to help eligible policyholders and their household members navigate life's challenges and maintain peace of mind. This program provides access to a variety of resources designed to support mental, emotional, and physical well-being. Services include counseling for legal, financial, and work-life balance concerns, with up to three sessions per issue per year, conducted by Master's or PhD-level counselors.

Additionally, the Guidance Resources platform offers tools and information on topics such as health, wellness, family, relationships, and finances, along with articles, podcasts, videos, and expert advice. Employees also have access to Well-being Coaching, which provides one-on-one telephonic sessions with certified coaches to address personal challenges like stress management, weight loss, and time management, with up to five sessions per year. The FamilySource program offers customized support for managing home, work, and family concerns, including childcare, elder care, adoption, education, and pet care. These services are available 24/7 by phone at **(800) 344-9752** or online at **guidanceresources.com** (use Organization Web ID: NYLGBS to register). Note that these programs are not insurance and may have restrictions or additional costs depending on the employer's plan.

401(K) RETIREMENT PLAN

Employees may elect to participate in the traditional pre-tax 401(k) or the Roth 401(k) after-tax Retirement Savings Plan or a combination there of The 401(k) Retirement Savings Plan offers varied investment options via July Services website **julyservices.com** to assist employees in the planning of their personal retirement fund.

- 2027 pre-tax contribution limits: $25,500; $34,000 for age 50+; $37,250 for ages 60–63 (super catch-up).*
- You must be 21 years of age at the date of entry.
- You are eligible to participate on the first of the month following your date of hire.
- Academy of Art University provides a discretionary match of 50% up to the first 6% of compensation contributed to the plan. If matching contributions are made, they will be funded annually. You are eligible for the Academy's contribution on the first day of the next quarter after being employed for one year if you have worked 1,000 hours within your first year of employment or within any following calendar year. To receive the match, you must be employed on the last day of the plan year. If you have terminated employment prior to the last day of the plan year, you must have 500 hours of service during the plan year.
- Beneficiaries need to be entered online at **julyservices.com** or call **(888) 333-6315**.
- Cerity Partners provides comprehensive wealth planning services tailored to individual needs. Their approach combines personalized investment strategies with holistic financial planning, including asset allocation, risk management, and tax optimization. Services extend to retirement and estate planning, aiming to create cohesive solutions that address all aspects of a client's financial life. Call **(800) 563-7166** or email **wealthhealth@ceritypartners.com** and ask for financial wealth planning supporting the Academy of Art University 401(k) program.

* Beginning in 2026, if you are 50 or older and you earned over $145,000.00 in wages last year, your catch-up contributions must go into a Roth account.

CONTACT 401K (JULY SERVICES)

Phone: (888) 333-6315

Website: julyservices.com

Additional Benefits and Perks (continued)

CREDIBLEMIND

It's ok, not to be ok! CredibleMind: The One Stop Shop for Mental Wellbeing Resources. CredibleMind is the free online platform that brings together expert rated and vetted videos, podcasts, apps, online programs, books and articles all in one easy to use place.

Confidential and available 24/7, with CredibleMind you can learn new skills, understand your own mental health, take a mental health assessment and browse our library of thousands of mental wellbeing resources. CredibleMind covers over 200 topics including:

- Stress
- Burnout
- Anxiety
- Depression
- Relationships
- Mindfulness
- Resilience
- Coping w/Medical Diagnosis
- Time-Management
- Happiness
- Sleep
- Parenting
- Grief and Loss
- Flourishing
- Substance Use
- Aging

Get started today by signing up and taking a mental health assessment. By signing up, you will have access to: past assessment results to track improvement over time, your favorite resources, and handpicked CredibleMind resources right to your email!

No matter what you are going through, CredibleMind has resources to help with science-backed evidence you can trust. Visit **relation.crediblemind.com** to get started today!

Your Privacy Matters Your personal information including your name, email address and responses will not be shared with your employer.

VOLUNTARY PET INSURANCE

We know how much you love your furry kids at home. We also know how expensive veterinary care can be. That's why we are excited to announce the addition of Figo Pet Insurance to our benefits package!

What you get when you purchase one of Figo's pet health insurance plans:

1. Reimbursement for your pet's unexpected medical costs
2. 10% discount
3. Figo's Pet Cloud mobile app to manage your pet's records, reminders and travel
4. Figo's pet tag with digital pet profile - allowing anyone who finds your pet to group text your family
5. Figo travel water bowl

To receive your employee discount and customize your quote now, visit: **https://bit.ly/323bIAi**

CONTACT FIGO

Phone: (844) 738-3446 **Text:** (844) 262-8133

Email: support@insurefigo.com

Carrier Contacts

INSURANCE COMPANY	GROUP NUMBER	CUSTOMER SERVICE NUMBER	WEBSITE
MEDICAL PLANS • Kaiser HMO • Anthem Select HMO • Anthem CaliforniaCare HMO • Anthem Prudent Buyer PPO	**Kaiser:** 39603 **Anthem:** L15558	**Kaiser HMO:** (800) 464-4000 **Anthem HMO:** (833) 913-2236 **Anthem PPO:** (800) 888-8288	kp.org anthem.com
HEALTH SAVINGS ACCOUNT • HSA Bank	N/A	(800) 357-6246	hsabank.com
HEALTH REIMBURSEMENT ACCOUNT • HSA Bank	N/A	(800) 357-6246	hsabank.com
DENTAL PLAN • Anthem Dental	L15558	(844) 729-1565	anthem.com
VISION • Anthem Vision	L15558	(866) 723-0515	anthem.com
FLEXIBLE SPENDING ACCOUNT • HSA Bank	N/A	(800) 357-6246	hsabank.com
401(k) PLAN • July Services • Cerity Partners	N/A	(888) 333-6315 (800) 563-7166 **Email:** WealthHealth@ceritypartners.com	julyservices.com
DISABILITY INSURANCE • NY Life Short Term Disability • NY Life Long Term Disability	LK964307	(800) 362-4462	N/A
VOLUNTARY SUPPLEMENTAL HEALTH PLANS • Anthem	L15558	(888) 828-2432	anthem.com
BASIC & VOLUNTARY LIFE/AD&D • NY Life	**Life:** FLX966279 **AD&D:** OK967818	(800) 362-4462	N/A
EMPLOYEE ASSISTANCE & WELLNESS SUPPORT • NY Life	Web ID: NYLGBS	(800) 344-9752	guidanceresources.com
COMMUTER PROGRAM • Edenred	1539	(888) 235-9223	login.edenredbenefits.com/
TRAVEL ASSISTANCE • NY Life Secure Travel	N/A	(888) 226-4567 (US and Canada) (202) 331-7635 (collect) **Email:** ops@us.generaliglobalassistance.com	N/A
PET INSURANCE • Figo	N/A	(844) 738-3446 phone (844) 262-8133 text **Email:** support@insurefigo.com	https://bit.ly/323blAi
CREDIBLEMIND	N/A		relation.crediblemind.com
ARTU BENEFITS TEAM	N/A		Benefits@academyart.edu
BENEFIT ADVOCATE • Relation Benefits Helpline	N/A	844-ArtU-111 (844)-278-8111	ArtUBenefits@ relationinsurance.com

This guide is intended as a quick reference, not a comprehensive description. There are some limitations and exclusions to these benefits that can be found in the official plan document. The official plan document will govern in case of any discrepancies.

2027 Federal Notices

2027 FEDERAL NOTICES (ANNUAL)

This package contains the required Federal notices for all employees eligible to enroll in our employee benefit program. Read carefully and keep in a secure place.

- HIPAA Special Enrollment Rights Notice
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Medicare Part D Creditable Coverage Disclosure Notice
- Women's Health and Cancer Rights Act Notice
- Newborns and Mothers' Health Protection Act Notice
- HIPAA Notice of Privacy Practices Reminder
- No Surprise Billing Notice

For questions about the notices, please contact us at **benefits@academyart.edu**

2027 Federal Notices

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

Loss of Other Coverage: If you have declined or will be declining enrollment for yourself and/or your dependents because of other in force health plan coverage, you may be able to enroll yourself and/or your dependents in this plan in the future. If you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards other group health plan coverage, it may trigger a special enrollment right.

You must request enrollment in this plan within 30 days after the other coverage ends. You will be required to submit proof of prior coverage, such as a coverage termination letter from an insurance company or employer.

New Dependent: If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents. This triggers a special enrollment right. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. You will be required to submit proof of a newly eligible dependent, such as a marriage certificate or birth certificate.

Termination of Medicaid or CHIP Coverage: If you and/or your dependents are covered under a Medicaid plan or a state child health insurance plan (CHIP), and coverage under such a plan is terminated because of loss of eligibility, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date Medicaid or state sponsored CHIP coverage ends.

Eligibility for Premium Assistance Under Medicaid or CHIP: If you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right. This is usually a program where the state provides employed individuals with premium payment assistance for their employer's group health plan, rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP.

2027 Federal Notices

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-KIDSNOW 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 July 31, 2026. Contact your State for more information on eligibility.

ALABAMA – MEDICAID
http://myalhipp.com/
855.692.5447

ALASKA – MEDICAID
The AK Health Insurance Premium Payment Program
http://myakhipp.com
1.866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – MEDICAID
http://myarhipp.com/
1.855.MyARHIPP (855.692.7447)

CALIFORNIA – MEDICAID
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
916.445.1248
Fax: 916.440.5676
Email: **hipp@dhcs.ca.gov**

COLORADO – HEALTH FIRST COLORADO
(Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1.800.221.3943/State Relay 711
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1.800.359.1991/State Relay 711

Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1.855.692.6442

FLORIDA – MEDICAID
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
1.877.357.3268

GEORGIA – MEDICAID
GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678.564.1162, Press 1
GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: 678.564.1162, Press 2

ILLINOIS – MEDICAID
Medicaid application website: **https://abe.illinois.gov**
HIPP Hotline Number: 217-524-8268
HIPP Email: **mhfs.boc.hipp@illinois.gov**

INDIANA – MEDICAID
Health Insurance Premium Payment Program
All other Medicaid
https://www.in.gov/medicaid/
1-800-457-4584
Family and Social Services Administration
https://www.in.gov/fssa/dfr/
1-800-457-8283

2027 Federal Notices

IOWA – MEDICAID and CHIPI (Hawki)
https://hhs.iowa.gov/programs/welcome-iowa-medicaid
1.800.338.8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1.800.257.8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1.888.346.9562

KANSAS – MEDICAID
https://www.kancare.ks.gov/
1.800.792.4884
HIPP Phone: 1.800.967.4660

KENTUCKY – MEDICAID
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
1.855.459.6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
1.877.524.4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – MEDICAID
https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – MEDICAID
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
1.800.442.6003/State relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
1.800.977.6740/State relay 711

MASSACHUSETTS – MEDICAID AND CHIP
https://www.mass.gov/masshealth/pa
1.800.862.4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – MEDICAID
https://mn.gov/dhs/health-care-coverage/
1.800.657.3672

MISSOURI – MEDICAID
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
573.751.2005

MONTANA – MEDICAID
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1.800.694.3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – MEDICAID
https://dhhs.ne.gov/Pages/Medicaid-and-Long-Term-Care.aspx
402-471-3121
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – MEDICAID
http://dhcfp.nv.gov
1.800.992.0900

NEW HAMPSHIRE - MEDICAID
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
603.271.5218
HIPP program: 1.800.852.3345, ext 15218

NEW JERSEY – MEDICAID AND CHIP
Medicaid: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/
800.356.1561
CHIP Premium Assistance: 609.631.2392
CHIP: http://www.njfamilycare.org/index.html
1.800.701.0710/State relay 711

NEW YORK – MEDICAID
https://www.health.ny.gov/health_care/medicaid/
1.800.541.2831

NORTH CAROLINA – MEDICAID
https://medicaid.ncdhhs.gov/
919.855.4100

NORTH DAKOTA – MEDICAID
https://www.hhs.nd.gov/healthcare/medicaid
800-755-2604

OKLAHOMA – MEDICAID AND CHIP
http://www.insureoklahoma.org
1.888.365.3742

OREGON – MEDICAID and CHIP
http://healthcare.oregon.gov/Pages/index.aspx
1.800.699.9075

PENNSYLVANIA – MEDICAID and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
1.800.692.7462
CHIP: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

2027 Federal Notices

PENNSYLVANIA – MEDICAID and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medic-aid-health-insurance-premium-payment-program-hipp.html
1.800.692.7462
CHIP: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – MEDICAID
http://www.eohhs.ri.gov/
1.855.697.4347, or 401.462.0311 (Direct RI Share Line)

SOUTH CAROLINA – MEDICAID
https://www.scdhhs.gov
1.888.549.0820

SOUTH DAKOTA – MEDICAID
https://dss.sd.gov/medicaid/
605-773-4678

TEXAS – MEDICAID
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
1.800.440.0493

UTAH – MEDICAID AND CHIP
Medicaid: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 888.222.2542
Adult Expansion: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/
CHIP: https://chip.utah.gov/

VERMONT – MEDICAID
https://dvha.vermont.gov/members/medicaid/hipp-program
1.800.250.8427

VIRGINIA – MEDICAID AND CHIP
Medicaid: https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP: 1.800.432.5924

WASHINGTON – MEDICAID
https://www.hca.wa.gov/
1.800.562.3022

WEST VIRGINIA – MEDICAID AND CHIP
https://bms.wv.gov/
http://mywvhipp.com
Medicaid Phone: 304.558.1700
1.855.MyWVHIPP (1.855.699.8447)

WISCONSIN – MEDICAID AND CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
1.800.362.3002

WYOMING – MEDICAID
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
1.800.251.1269

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

PAPERWORK REDUCTION ACT STATEMENT

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

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

OMB Control Number 1210-0137 (Expires 5/31/2029)

Please keep this notice in a secure place with your other health plan materials.

2027 Federal Notices

MEDICARE PART D DISCLOSURE NOTICE

Important Notice about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about our company's group health plan prescription drug coverage, and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Our company's group health plan is, on average for all plan participants, expected to pay as much as the standard Medicare prescription drug coverage will pay, and is considered "creditable coverage."

Because our plan is considered creditable coverage, you can enroll and/or stay enrolled in our plan, and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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. All Medicare prescription 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.

Individuals (employees and/or their dependents) may enroll in a Medicare prescription drug plan when they first become eligible for Medicare, and each year from October 15th through December 7th, the annual Medicare Open Enrollment Period, with coverage effective on January 1st. Individuals leaving a group health plan during other times of the year may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.

If you 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 may not be able to get this coverage back. See below for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with your employer's group health plan and do not enroll in Medicare prescription drug coverage within 63 days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium may go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may always be at least 19% higher than the regular premium. You will 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 Medicare Open Enrollment Period to enroll.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail from Medicare every year. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov**, or call them at (800) 772-1213; TTY (800) 325-0778).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare that offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you have maintained creditable coverage and are not required to pay a higher premium amount (a penalty).

Last Updated: April 1, 2011 (Current August 1, 2023)

2027 Federal Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

This law requires group health plans providing coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. We are pleased to inform you that your medical coverage follows this law.

As the Act requires, we have provided you this letter to inform you about the law's provisions. The law mandates that a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed.
- surgery and reconstruction of the other breast to produce a symmetrical appearance.
- prostheses; and
- treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient and will be subject to the same annual deductibles and coinsurance provisions applicable to the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your medical ID card.

NEWBORNS AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and insurers may not require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Our organization would like to communicate the availability of its Notice of Privacy Practices. At any time, a copy of the current Notice of Privacy Practices may be obtained by contacting Human Resources.

2027 Federal Notices

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

2027 Federal Notices

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, the federal phone number for information and complaints is: 1-800-985-3059.

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