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What's new in 2019?
In 2019, ConnectYourCare becomes the administrator of the Flexible Spending Accounts (FSAs) and commuter benefits. ConnectYourCare's user-friendly site will make FSA claims and commuter benefits easier to administer and the monthly FSA fee has been lowered.

We have enhanced our legal plan, at no additional cost, to include identity management services to assist when you think that your personal data has been compromised.
American University provides a comprehensive and competitive benefits package that supports you and your family. The *Know Your Benefits Enrollment Guide* explains your benefits in detail and is a companion piece to the benefits information on www.american.edu/hr/benefits.

Benefit elections are made on the myBenefits website which is accessible through the myAU portal. Use the enrollment guide and the information on myBenefits to review your current benefit options and access the online enrollment system to make your 2019 benefit elections. New hires and employees making changes due to qualifying life events in 2019 will also use the myBenefits online enrollment system.

**Changes for 2019**

ConnectYourCare will become the administrator of the Flexible Spending Accounts (FSAs) and commuter benefits. FSA benefits remain the same, but the FSA monthly fee has been lowered and the health care and dependent care spending accounts’ plan administration will be easier. ConnectYourCare has a user-friendly site with added conveniences for commuter benefit transactions.

We will continue to offer two medical options in 2019. The CareFirst rates will increase 8% and the PPO plan design has changed to help moderate the cost increase and to bring it more in line with peer plans. No changes have been made to the prescription drug benefit. Kaiser rates will decrease by 2.5% in 2019 with no plan design changes.

We have enhanced our legal plan, at no additional cost, to include identity management services to assist when you think that your personal data has been compromised. The rates and plan provisions for the dental, life, and disability plans will remain the same as 2018.

Our success at AU depends on the contributions and commitment of our faculty and staff. Thank you for your work to move the university forward as it strives to achieve its strategic goals. The Office of Human Resources is here to support you throughout the year.

We invite your feedback and questions about this guide, the myBenefits site, or our benefits offering. Please contact myBenefits@american.edu or call (202) 885-3400.

Beth Muha
Assistant Vice President of Human Resources
Enrollment Information

American University provides you with a comprehensive and competitive benefits package to support you and your family.

Some benefits, such as medical and dental, require enrollment during specific enrollment windows. Other voluntary benefits, such as contributions to the AU 403(b) Retirement Plan, can be made at any time throughout the year.

For more information about any of American University's benefits, visit the Benefits site on www.american.edu/hr.

This guide provides full descriptions of AU’s benefit programs and navigates you through the enrollment process.

You may enroll in most of the university benefit plans:

- After you are initially hired;
- During the annual open enrollment period; and/or
- At the time of a qualifying life event.

For new hires enrolling in AU’s health, dental, flexible spending accounts, and legal plan, coverage begins on the first of the month after you start. If you start on the first of the month, your benefits will start that day.

For benefits that require enrollment during one of the enrollment periods listed above, if enrollment is not completed during these times, you will have to wait until the next open enrollment to apply for or make changes to coverage. See the section “Making Changes During the Year” for details on page 6.

Why can I only make changes to these plans once per year?

The Internal Revenue Service (IRS) regulates plans that allow pre-tax contributions for benefits. The IRS permits you to make changes to your coverage only during open enrollment or when you experience certain qualifying life events (such as marriage, birth, adoption of a child, etc.).

Your Enrollment Options at a Glance

You may choose to enroll in the following benefits when you are hired, during open enrollment, or if you have a qualifying life event.

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>PLAN OPTIONS</th>
</tr>
</thead>
</table>
| Medical  | CareFirst BlueChoice Advantage Plan  
          | Kaiser Permanente Signature Plan HMO |
| Prescription Drug | Express Scripts (included in CareFirst BlueChoice Advantage medical)  
                   | Kaiser Permanente (included in Kaiser Permanente medical) |
| Dental   | Delta Dental Basic and Comprehensive Plans |
| Life     | Optional Life Insurance |
| Personal Accident | Voluntary Personal Accident Insurance |
| Legal    | Hyatt Legal's MetLaw Plan |
| Flexible Spending Accounts | Health Care Spending Account (Administered by ConnectYourCare)  
                             | Dependent Care Spending Account (Administered by ConnectYourCare) |

What if I made an election and then decided that another choice would be better?

During the open enrollment period, you can make a change to your plan. As a new hire, or if your change is due to a qualifying life event, you can make another choice as long as you are still within 30 days of hire or event. In all cases, please call Human Resources at x2591 with any questions.

How do I make changes to my benefits outside of open enrollment?

Enroll through the myBenefits site accessible on the myAU portal > Work@AU > Benefits: myBenefits. Enroll or change your benefit elections within 30 days of your qualifying life event, along with documentation to support your life event.
Enrollment Information

How to Enroll

New Hires
Attend a new hire orientation to receive an overview of AU’s benefit plans. You will receive information on our online enrollment system. Your benefits enrollment must be completed within 30 days of your start date.

During Open Enrollment
From November 5 – 26, 2018, you can make your open enrollment elections online at the myBenefits site, accessible through the myAU portal, hover over the Work@AU tab, and then click Benefits: myBenefits.

During the Year
Go to the myBenefits site accessible through the myAU portal, hover over the Work@AU tab and click on Benefits: myBenefits. Complete and submit your enrollment within 30 days of your qualifying life event, along with documentation to support the life event.

If You Do Not Enroll

Within 30 Days of Becoming Eligible
(For new hires/qualifying life events)
You will not have medical, dental, group legal, flexible spending account(s), optional life, or personal accident coverage, and you will not be able to make changes to your coverage until the next open enrollment period, unless you experience a qualifying life event.

You will be enrolled automatically in the university-provided basic life insurance. Short term disability coverage begins at the start of contract for faculty and after six months of full-time service for staff. After one year of service, you will be covered by the university's long term disability plan and, if you have not yet enrolled, you will be enrolled automatically in the AU Retirement Plan and your 1% contribution will be matched by 2% from the university.

During Open Enrollment
You will not be able to make changes to your coverage until the next open enrollment period, unless you have a qualifying life event.

Will I receive notice that my open enrollment benefit elections have been received?
Yes. You will receive an email confirmation that your open enrollment elections were completed successfully.
You can confirm your benefit elections by reviewing your benefit elections in the myBenefits online enrollment system or by your pay advice located on the myAU portal > Work@AU > Eagle Service - Earning Statements.

2019 OPEN ENROLLMENT
Make Your Elections

These plans will rollover automatically unless you change your election:

- Medical
- Dental
- Legal
- Current life and personal accident insurance elections

Your 403(b) Retirement Plan contributions and asset allocations may be changed at any time. Visit the myBenefits - Retirement site for more information.

You must take action for the following as they do not rollover automatically:

- Health care flexible spending account
- Dependent care flexible spending account
Eligibility

You are eligible for the coverage described in this guide if you are a full-time faculty or staff member as defined in the Faculty/Staff Benefits Manual.

Eligible Dependents

Children, Spouse, or Opposite- or Same-Sex Domestic Partners

You also can enroll your eligible dependents for medical, dental, legal, and life insurance coverage. Your dependents may include your spouse, opposite- or same-sex domestic partner, and eligible dependent children. Opposite- and same-sex domestic partners may be added to the plan as long as you meet eligibility requirements and have a valid Affidavit of Domestic Partnership on file in Human Resources.

Children

Eligible children include your children, stepchildren, legally adopted children, children who have been placed with you for adoption, and children for whom you have been appointed legal guardian. In most cases, your dependent children are eligible until the end of the year in which they reach age 26.

<table>
<thead>
<tr>
<th>PLAN</th>
<th>AGE LIMITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareFirst, Kaiser Permanente, Delta Dental, VisionAccess, and Hyatt Legal’s MetLaw plan</td>
<td>From live birth to age 26 Any age if disabled*</td>
</tr>
<tr>
<td>Dependent Life Insurance</td>
<td>From live birth to age 26</td>
</tr>
</tbody>
</table>

*Disabled children who are incapable of supporting themselves due to a mental or physical disability (provided the disability occurred before the child reached age 26).

AU reserves the right to require documentation of a dependent’s eligibility at any time. You should refer to the appropriate sections of the Faculty/Staff Benefits Manual or the official plan documents for more extensive benefits plan information.

Commonly Asked Questions

What coverage is available for my domestic partner?

A same-sex or opposite-sex domestic partner may be covered under your medical, dental, vision, life insurance, legal, and personal accident plans. A same-sex domestic partner also is eligible for education benefits. Opposite-sex domestic partners are not eligible for education benefits.

Who qualifies for coverage as a domestic partner?

A domestic partnership is defined as two individuals who live together in a long term relationship; share a close personal relationship and are responsible for each other’s common welfare; are each other’s sole domestic partner; have not had another domestic partner within the past year; and are not related by blood closer than would bar marriage in the District of Columbia. You must have a valid Affidavit of Domestic Partnership on file with Human Resources.

Are children of my domestic partner eligible for coverage?

A child’s eligibility depends on the child’s relationship to the employee. A child related to the employee by blood, adoption, legal custody, or guardianship would qualify as a dependent.

What is imputed income and why does it apply to benefits for my domestic partner?

The IRS requires that the value of benefits provided for a person who is not your dependent for federal income tax purposes be subject to taxation. The value of your partner’s benefits may be considered income to you and, if so, is added to your total income for tax purposes. This added “income” is called imputed income. Please note that health benefits for domestic partners registered in the District of Columbia are not subject to DC income tax. You will need to submit proof of registration to Human Resources.

When does a domestic partner become ineligible for coverage?

A domestic partner’s eligibility under the medical, dental, or vision plan will end on the earliest of:

• The end of the month following an employee’s date of termination, or
• The end of the month in which the individual no longer satisfies the eligibility criteria for domestic partner status.

Faculty and staff must notify Human Resources immediately of any changes in eligibility status.
## For Your Consideration

Are you a new hire? Do you need to make changes during open enrollment? Consider these questions.

<table>
<thead>
<tr>
<th>THINK ABOUT . . .</th>
<th>YES</th>
<th>NO</th>
<th>WHY . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you want to change your medical plan?</td>
<td>☐</td>
<td>☐</td>
<td>Consider whether the Delta Dental Comprehensive or the Basic Plan may work best for you and your family.</td>
</tr>
<tr>
<td>Do you want dental coverage?</td>
<td>☐</td>
<td>☐</td>
<td>Choose the Delta Dental Comprehensive Plan for adult and child orthodontia coverage.</td>
</tr>
<tr>
<td>Will someone in your family need braces next year?</td>
<td>☐</td>
<td>☐</td>
<td>Choose the Delta Dental Comprehensive Plan for adult and child orthodontia coverage.</td>
</tr>
<tr>
<td>Will someone in your family need glasses next year?</td>
<td>☐</td>
<td>☐</td>
<td>Consider using MetLife VisionAccess Program and adding a health care flexible spending account for medical expenses, including eye wear.</td>
</tr>
<tr>
<td>Do you want to change the amount of your life insurance?</td>
<td>☐</td>
<td>☐</td>
<td>You must enroll (or re-enroll) each year. In 2019, the limit is $2,650*.</td>
</tr>
<tr>
<td>Do you want to change who you cover?</td>
<td>☐</td>
<td>☐</td>
<td>You must enroll (or re-enroll) each year. In 2019, the limit is $5,000.</td>
</tr>
<tr>
<td>Do you want a health care flexible spending account in 2019?</td>
<td>☐</td>
<td>☐</td>
<td>You may make changes to your Retirement Plan at any time during the year.</td>
</tr>
<tr>
<td>Do you want to have a dependent care flexible spending account in 2019?</td>
<td>☐</td>
<td>☐</td>
<td>Enroll in Hyatt Legal’s MetLaw Plan.</td>
</tr>
<tr>
<td>Do you want to contribute or change your contributions to your 403(b) Retirement Plan?</td>
<td>☐</td>
<td>☐</td>
<td>You must enroll to elect the benefit, but may do so at any time.</td>
</tr>
<tr>
<td>Do you want group auto or home coverage?</td>
<td>☐</td>
<td>☐</td>
<td>You must enroll to elect the benefit, but may do so at any time.</td>
</tr>
</tbody>
</table>

*At the time of printing of this benefits guide, the IRS had not yet released the 2019 benefits limits.
Making Changes During the Year

You can change your medical, dental, life insurance, and flexible spending account coverage during the year, according to IRS rules, only when you experience a qualifying life event, such as:

- Marriage, divorce, or legal separation
- Death of a spouse, domestic partner, or dependent
- Birth or adoption of a new dependent or gaining legal custody of a new dependent
- A change in a dependent’s eligibility status
- Employment change for a spouse or domestic partner
- A change in your employment status or that of your spouse or domestic partner
- A change of your residence

You must make a coverage change due to a qualifying life event within 30 days of the event, and the election change must be consistent with the event. For example, if your dependent child no longer meets eligibility requirements (e.g., your child reaches age 26), you can drop coverage only for that dependent.

Other Benefits

American University also provides you with a comprehensive offering of other benefits that are available for you to elect or make changes to throughout the year:

- Defined Contribution 403(b) Retirement Plan
- AhealthyU, AU’s Faculty and Staff Wellness Program
- Subsidized Membership in the Cassell and Jacobs Fitness Centers and Discounted Off-site Gym Memberships
- Short and Long Term Disability Insurance
- Education Benefit Programs
- Dependent Care/Family Services & Resources
- VisionAccess Program
- Pet Insurance
- Group Auto and Home Insurance
- Pre-Tax Parking and Pre-Tax Commuter Benefits
- Bicycle Commuter Benefit

For more details, please see the “Other Benefits, Information & Notices” section starting on page 28 of this guide.

Will the medical or dental plans require Evidence of Insurability as an enrollment requirement for legal spouses, children or domestic partners?

No. There are no Evidence of Insurability requirements for any individual under the medical and dental plans.
## Your Cost for Coverage

<table>
<thead>
<tr>
<th>Plans</th>
<th>2019 Rates</th>
<th>2018 Rates</th>
<th>2019 AU Share/Month</th>
<th>2019 Employee Share/Month</th>
<th>2019 Employee Change/Month</th>
<th>2019 Employee Share/Bi-Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareFirst &amp; Express Scripts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual under $35K</td>
<td>$730.85</td>
<td>$676.71</td>
<td>$694.31</td>
<td>$36.54</td>
<td>+$2.70</td>
<td>$16.86</td>
</tr>
<tr>
<td>Individual over $35K</td>
<td>$730.85</td>
<td>$676.71</td>
<td>$584.68</td>
<td>$146.17</td>
<td>+$10.83</td>
<td>$67.46</td>
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<tr>
<td>Individual plus one</td>
<td>$1,460.33</td>
<td>$1,352.16</td>
<td>$949.21</td>
<td>$511.12</td>
<td>+$37.86</td>
<td>$235.90</td>
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<td>Family</td>
<td>$2,117.04</td>
<td>$1,960.22</td>
<td>$1,376.08</td>
<td>$740.96</td>
<td>+$54.88</td>
<td>$341.98</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Individual under $35K</td>
<td>$518.76</td>
<td>$531.97</td>
<td>$492.82</td>
<td>$25.94</td>
<td>-$0.66</td>
<td>$11.97</td>
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<tr>
<td>Individual over $35K</td>
<td>$518.76</td>
<td>$531.97</td>
<td>$415.01</td>
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<tr>
<td>Individual plus one</td>
<td>$1,040.27</td>
<td>$1,066.73</td>
<td>$676.18</td>
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<td>$168.04</td>
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<tr>
<td>Family</td>
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<td>Delta Dental Comprehensive</td>
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<tr>
<td>Individual</td>
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<td>$38.60</td>
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<td>$13.36</td>
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<tr>
<td>Individual plus one</td>
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<td>$77.21</td>
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<td>Family</td>
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<td>$111.91</td>
<td>$22.38</td>
<td>$89.53</td>
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<tr>
<td>Delta Dental Basic</td>
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<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$30.68</td>
<td>$30.68</td>
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<td>$23.01</td>
<td>$0.00</td>
<td>$10.62</td>
</tr>
<tr>
<td>Individual plus one</td>
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<td>$61.35</td>
<td>$12.27</td>
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<td>Hyatt Legal's MetLaw Plan</td>
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<tr>
<td>Individual</td>
<td>$16.50</td>
<td>$16.50</td>
<td>$0.00</td>
<td>$16.50</td>
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<td>$7.62</td>
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<tr>
<td>Family</td>
<td>$16.50</td>
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<td>$0.00</td>
<td>$16.50</td>
<td>$0.00</td>
<td>$7.62</td>
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<tr>
<td>Flexible Spending Account</td>
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<tr>
<td>Fee</td>
<td>$2.95</td>
<td>$6.00</td>
<td>$1.50</td>
<td>$1.45</td>
<td>-$1.80</td>
<td>$0.67</td>
</tr>
<tr>
<td>Vision Discount</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>All eligible family members</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>Pet Insurance</td>
<td></td>
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<tr>
<td>Nationwide® Plans</td>
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<tr>
<td>Varies</td>
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<tr>
<td>Optional Life Insurance</td>
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<td>Optional Life</td>
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<td>Varies</td>
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</table>
Medical Coverage

As a foundation for your healthy life, AU provides you with a choice of two medical plans:

- **CareFirst BlueChoice Advantage Plan** offers the flexibility to choose from BlueChoice and BluePreferred PPO providers locally and BlueCard PPO providers nationwide for in-network benefits as well as out-of-network providers.
- **Kaiser Permanente HMO** utilizes a local network of facilities and providers.

Both medical plans offer many online tools, resources, and access to wellness discounts. Check their websites for more information on: 1) health improvement tools & trackers; 2) wellness products and discounts (weight loss programs, sports clubs, massage therapy, and more).

Cost

The university contributes 80% towards individual coverage and 65% for individual plus one and family coverage of the total cost of your medical premium.

Your portion of the cost for medical coverage is deducted from your pay on a pre-tax basis. Insurance premiums effective January 1, 2019 are shown on page 7 of this guide.

Pre-Tax Contributions

Pre-tax contributions come out of your pay before federal, Social Security, and (in most cases) state and local taxes are applied. Since your pre-tax contribution is not included as income on your W-2 earnings statement, it will reduce your taxable income. You may be able to make pre-tax contributions on behalf of a domestic partner. Please contact Human Resources at x2591 for more information. In addition, your pre-tax contributions for a given year will reduce your Social Security wage base for that year. This may result in a slight reduction in your Social Security benefits when you retire.

Coverage Levels

When you enroll, you will be able to elect one of the following coverage levels:

- Individual
- Individual plus one
- Family

You can enroll yourself, one other qualified adult member (spouse or domestic partner) of your household, and your dependent children.

During open enrollment, you may:

- Enroll in the medical plan to have medical coverage in 2019
- Drop coverage
- Add or remove dependents (i.e., change your coverage level)

If you are not covered currently under a medical plan and you do not enroll for coverage during open enrollment, or if you elect to cancel your coverage, you may not enroll until the next open enrollment except as summarized in the “Making Changes During the Year” section on page 6.

Choosing a Medical Plan

Choosing a medical plan can be challenging so we provide this information to help you make an informed choice about your medical plan. The information on the following pages is an overview of the different types of coverage available under the AU medical plans. In addition, there are health plan comparison charts on pages 42 – 52.

Finding a Network Doctor

Use the online provider directories for each plan. Under the CareFirst plan, it is the employee’s responsibility to ensure that their provider participates in-network. Contact your new and existing providers and ask if they still participate or if they are considered ‘in-network’ with the plan. If you need help accessing the online provider directories, please contact Human Resources at x2591.

Which medical plan will be the best choice for my family?

We recommend reviewing this guide and taking into consideration your family’s medical needs. The Kaiser plan generally costs less out-of-pocket than CareFirst and you see physicians in the Kaiser center. With CareFirst, you may see any doctor but how much you pay depends on whether the provider participates in the BlueChoice or PPO networks. The national in-network providers cover dependents that are out of the local area. Additionally, Kaiser in-network CareFirst doctors will file your claims. If you are in CareFirst and see an out-of-network doctor, you may have to file your own claim.
Medical Plan Options

CareFirst BlueChoice Advantage

CareFirst BlueChoice Advantage offers you the flexibility and freedom to choose from both in- and out-of-network providers. With the BlueChoice Advantage plan, you are not required to designate a Primary Care Provider (PCP) or to obtain a referral to see a specialist. However, we recommend that you select a Patient Centered Medical Home (PCMH) PCP to provide comprehensive care coordination. A PCMH PCP can help you to better manage your health care needs and overall well-being. Learn more about PCMH support on page 10.

- **In-network** means you have lower out-of-pocket costs when you choose either a BlueChoice, BluePreferred PPO, or BlueCard PPO network provider.
  - If you are out of the CareFirst service area (Maryland, DC, and the Northern Virginia counties of Fairfax, Alexandria and Arlington), you may choose any provider nationwide that participates with a BlueCard PPO plan and receive in-network benefits.

- **Out-of-network** provides a lower level of coverage in exchange for the freedom to seek care from any provider you choose. If you receive services from a provider outside of the BlueChoice, BluePreferred PPO, or BlueCard PPO networks, you will have to:
  - Pay the provider’s actual charge at the time you receive care
  - File a claim for reimbursement (obtain claim forms at myBenefts or on the CareFirst website at www.carefirst.com)
  - Satisfy a deductible and coinsurance

What if my doctor is not a BlueChoice, BluePreferred PPO, or BlueCard PPO provider?

If your provider is not a participating doctor in either the BlueChoice, BluePreferred PPO, or BlueCard PPO networks, they are considered out-of-network. You will still have coverage, but your out-of-pocket costs will be greater.

To find an in-network provider, visit www.carefirst.com. Inside the CareFirst service area, select the BlueChoice Advantage plan.

- Outside of the Maryland, DC, and Northern Virginia region, go to www.BCBS.com. Enter the first three letters of your Member ID number on your insurance card in the “Already A Member” field.

Providers listed in this directory are considered in-network and you will have the lowest of out-of-pocket costs. It is the employee’s responsibility to verify that the provider still participates in-network before receiving care, see section on page 8 “Finding a Network Doctor.”

If your provider is not listed in either of these directories, they are considered out-of-network. You will still have coverage, but your out-of-pocket costs will be greater.

Do I need a Primary Care Provider (PCP) with CareFirst?

With the BlueChoice Advantage plan, you are not required to designate a primary care provider (PCP). However, we recommend that you select a Patient Centered Medical Home (PCMH) PCP to provide comprehensive care coordination. A PCMH PCP can help you to better manage your health care needs and overall well-being. When searching for doctors, select Primary Care Providers and you will be given the option to view providers participating in CareFirst’s Patient Centered Medical Home Program.
Medical Plan Options

How Your Choice of Provider Affects Your Out-of-Pocket Cost in the CareFirst Plan

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueChoice Preferred Provider</td>
<td>BlueChoice Preferred Provider</td>
</tr>
<tr>
<td>BlueChoice &amp; BlueCard</td>
<td>BCBS Participating Provider</td>
</tr>
<tr>
<td>Non-BCBS Provider</td>
<td>Non-BCBS Provider</td>
</tr>
</tbody>
</table>

Provider’s charge (office visit, X-ray and lab) $2,200 $2,200 $2,200

Plan’s allowable charge (negotiated rate) $1,200 $1,200 $1,200

AU Plan pays $780 (100% after $20 copayment) $130 (65% after $1,000 deductible) $130 (65% after $1,000 deductible)

YOU PAY

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible*</td>
<td>$400</td>
<td>$1,000</td>
</tr>
<tr>
<td>Office visit copayment</td>
<td>$20</td>
<td>Not applicable</td>
</tr>
<tr>
<td>35% of allowable charge after deductible</td>
<td>Not applicable</td>
<td>$70</td>
</tr>
<tr>
<td>Difference between the allowable charge and provider’s charge (balance billing)</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Your total out-of-pocket cost</td>
<td>$420</td>
<td>$1,070</td>
</tr>
</tbody>
</table>

*This example assumes that you have not satisfied the plan’s annual deductible ($400 for Individual in-network and $1,000 for Individual out-of-network). Once the deductible is met, patient pays only copayment/coinsurance. The rates are for illustrative purposes only and do not reflect actual service amounts.

24/7 Patient Support

CareEssentials Telephonic Support

CareEssentials is a health coaching resource for those who enroll in the CareFirst medical plan. (Kaiser Permanente has a similar program.) It is a personalized, confidential, and voluntary program that helps people with chronic conditions like diabetes or asthma to manage their overall health. Highly trained nurses provide one-on-one telephone support and health information; help you prepare questions for doctor visits; answer questions about new diagnoses and medications; and assist with other health issues. The CareEssentials team is available to support your relationship with your physician, not replace it. They will ensure coordination of care with your physician. The program is provided to you by CareFirst’s partner, Healthways, Inc., a leading provider of integrated health management.

Patient Centered Medical Home (PCMH) Physician Support (Only available to those under age 65)

Working in coordination with participating PCMH doctors, this program provides coordination of care for patients with serious and chronic health conditions. If your doctor participates, they will get streamlined access to specialist reports, test results, and hospitalization information. A nurse in your physician’s office is designated to be available to answer questions, support the treatment process, and be proactive in providing care. The program is confidential, voluntary, and provided at no additional cost to you. If you are contacted by your doctor, we strongly encourage you to enroll in the program so that you can get personalized care and support for you and your family. To find out if your physician participates, go to www.carefirst.com and look for the PCMH symbol near the provider’s name.
Medical Plan Options

Nurse Line: To ER or Not to ER?
Not sure whether your cold is strep throat? Or if your child's sore throat warrants a visit to the doctor or emergency room? Call the CareFirst FirstHelp™ Nurse Line at (800) 535-9700.

What is a medical emergency?
Emergencies are acute symptoms that are severe enough that avoiding immediate medical attention could result in:
- Serious jeopardy to your health
- Serious impairment in your bodily functions
- Serious dysfunction of any bodily organ or body part
Emergencies require a visit to the emergency room or call 911.

Urgent Care Centers
Urgent care centers are walk-in medical facilities that can treat minor emergencies. Most centers have evening and weekend hours should a condition require immediate attention, and you are unable to reach your primary care provider. You can often get treatment more quickly in an urgent care center than in the emergency room. For a list of participating urgent care centers, go to www.carefirst.com or call Member Services at (800) 628-8549.

Great Beginnings: Specialized Support for Expectant Mothers
Expectant mothers in the CareFirst medical plan may take advantage of the CareFirst Great Beginnings pregnancy support program designed to supplement the prenatal care and education you receive from your doctor, at no additional cost to you. When you enroll in Great Beginnings, a nurse case manager will review your medical history. If you experience complications during your pregnancy, they will work closely with your doctor to coordinate necessary services.

CareFirst is a Self-Insured Plan

What does it mean to have a self-insured plan?
A self-insured plan means the university pays the claims. CareFirst administers the claims from health providers for AU faculty and staff. The university does not receive any private medical information, nor any details about claims incurred.

Our premiums for CareFirst are based on our claims experience. If we have a lot of claims in a year, the university has to pay more. And that means the next year premiums go up, as our claims experience was not as good.

But you can help. When you choose generic medications, stick with your healthy regimens, and get preventive screenings, you generally incur less in claims. The lower our claims, the lower our premiums are the next year as we have had a better claims experience.

What is an urgent symptom?
Urgent care requires prompt medical attention within 24 to 48 hours, but is not an emergency medical condition.

Examples include:
- Minor Injuries
- Sore throats and upper respiratory symptoms
- Ear aches
- Back aches
Medical Plan Options

Kaiser Signature HMO

Kaiser Permanente provides comprehensive prepaid health care services through a system of health care network facilities. All health care is arranged or provided by a Primary Care Physician (PCP) of the Kaiser Center you select at the time you enroll. No benefits are provided for non-emergency services received outside the HMO network of providers. With Kaiser, generally you do not need to file claims, unless you were to receive out-of-area emergency care.

Kaiser has over 30 centers located throughout the Washington, DC metropolitan area, including centers in Gaithersburg, MD, Tysons Corner, VA, and Northwest DC at 2301 M Street. Some centers serve as after-hours care centers, where participants with urgent medical problems may be seen when regular medical centers are closed. With the exception of life threatening emergency treatment, participants must receive care through Kaiser centers. Hospitalization coverage is included at area hospitals associated with Kaiser.

• You must select a PCP in order to obtain care within the network; if you do not select a PCP, one will be assigned to you.
• As needed, your PCP will refer you to specialists within the network.
• Except in emergency situations, coverage is not provided for care received outside the network.
• You pay a copayment for some visits to a physician's office (see charts, pages 42-52).
• Set-up your member account at www.kaiserpermanente.org to access email and communicate with your physician, schedule appointments, obtain prescription refills, obtain test results, and review records of earlier visits.

Go to www.kaiserpermanente.org to locate a medical provider, and select your region (Maryland/Virginia/Washington DC).
Prescription Drug Coverage

Both medical plans provide prescription drug coverage for a wide selection of drugs. If you take certain medications on a regular basis, you can save money by purchasing prescriptions by mail order. With mail order prescriptions, you pay less and get convenient home delivery.

Your prescription drug coverage is in the form of a three-tier benefit structure based on a formulary (preferred drug list). The amount you pay varies, depending on whether you purchase a generic or brand name drug and whether the drug is included in your plan’s formulary (see chart).

To save out-of-pocket costs and help control the community’s health care costs, discuss with your doctor what medication is most appropriate for you based on your condition and out-of-pocket costs and ask if there is a generic or preferred brand equivalent. The majority of drugs prescribed by your doctor will already be on the formulary.

| GENERIC | A drug that meets the same standard quality and is an ingredient or therapeutic match to the brand name equivalent. Generic drugs cost less. |
| BRAND NAME PREFERRED (FORMULARY) | A drug that has no generic equivalent and is included on the plan’s preferred drug list (formulary). You will pay more for preferred brand name drugs than for generic drugs. |
| BRAND NAME NON-PREFERRED (NON-FORMULARY) | A drug that is not included on the plan’s preferred drug list for which there is an ingredient or therapeutic equivalent in the generic or brand name preferred tiers. These drugs are most costly. |

A formulary is a preferred drug list of safe and effective brand name drugs. Using generic or formulary drugs saves you money now. Those savings add up for all of us, as it can mean lower premium increases in the future. For formulary information for Express Scripts, go to www.express-scripts.com and for Kaiser, go to www.kaiserpermanente.org.

Home Delivery

Use the home delivery program for drugs you take on an ongoing basis for conditions such as arthritis, high cholesterol, diabetes, and high blood pressure.

This program is a great option to help you save on copayments. You can order a 60- to 90-day supply of maintenance medication by mail. Most medications are delivered right to your doorstep. Once your order is set up, you can request refills online or by phone. Order forms are available online.

| EXPRESS SCRIPTS (CareFirst Participants) | KAISER PERMANENTE |
| In-Network Pharmacy | Kaiser Center | Outside Pharmacy |
| GENERIC Drugs | $10 | $10 | $20 |
| Brand Name Formulary Drugs | 30% coinsurance to $30 max | $20 | $40 |
| Brand Name Non-Formulary Drugs | 50% coinsurance to $50 max | $35 | $55 |
| Supply | 1 month | 1 month | |
| Excluded Drugs* | 100% participant responsibility | Not applicable | |

| MAIL ORDER |
| GENERIC Drugs | $25 | $20 |
| Brand Name Formulary Drugs | 30% coinsurance to $75 max | $40 |
| Brand Name Non-Formulary Drugs | 50% coinsurance to $125 max | $70 |
| Supply | 90 days | 90 days | |
| Excluded Drugs* | 100% participant responsibility | Not applicable | |

| OUT-OF-POCKET MAXIMUM |
| Out-of-Pocket Maximum Individual* | $3,850 | Included with medical |
| Out-of-Pocket Maximum Individual + 1/Family* | $7,700 | Included with medical |

*Excluded drugs do not apply towards out-of-pocket maximums.
Prescription Drug Coverage

Prescription drugs that are included on the formulary are covered 100% after the copayment (Kaiser) or once you reach the maximum (CareFirst). Excluded drugs on the Express Scripts formulary do not apply towards the out-of-pocket maximum. Up to a 34-day supply of covered medications is provided unless the drug maker’s packaging limits the supply in some other way.

Brand-name drugs will be paid by coinsurance, rather than a copayment, with a maximum amount in place. For example, the full cost of ABC brand-name preferred drug is $90 for a 30-day supply. With coinsurance, you pay 30% of the cost (in this case $27) and the university pays the balance.

Maintenance medications are drugs you take on an ongoing basis for conditions such as arthritis, high cholesterol, diabetes, and high blood pressure. Kaiser and Express Scripts (CareFirst participants) help you save on copayments by allowing you to order a 60- to 90-day supply of maintenance medication by mail or at a Kaiser Center or at your local CVS pharmacy (CareFirst participants only). Once your order is set up, you can request refills online or by phone. Order forms are available online.

Kaiser

Prescriptions can be filled at a plan pharmacy located within a Kaiser facility or at a participating network/community pharmacy. Members may also choose to fill prescriptions for maintenance and other long term medications at a Kaiser facility or through the home delivery service offered through www.kaiserpermanente.org.

As described for CareFirst participants in the next section, Kaiser Permanente also has a step therapy program in place.

Express Scripts (CareFirst Participants)

Express Scripts is a third-party prescription drug benefit provider and not a part of CareFirst, so be sure to present your Express Scripts card to have your prescriptions filled at retail pharmacies. The Express Scripts Smart90 CVS program is an integrated feature of your pharmacy coverage. With it, you have two ways to get up to a 90-day supply of your long-term maintenance medication. You can conveniently fill these prescriptions either through Express Scripts home delivery or at a local CVS pharmacy for the same cost as home delivery.

Injectable and specialty drugs are available through CuraScript/Accredo, the specialty care prescription program available with Express Scripts.

Prior Authorization

Under the three-tier prescription drug program, there is a prior authorization requirement for some drugs. For these drugs, Express Scripts will require that physicians call Express Scripts for prior authorization before they write prescriptions and/or authorize refills on current prescriptions. To determine whether your prescription requires a prior authorization, call Express Scripts customer service or go online to www.express-scripts.com. Without prior authorization, you will pay the full price of the prescription rather than the coinsurance amount.

Express Scripts Smart90 CVS

Under this program, medications taken regularly (maintenance medications) can be filled through Express Scripts home delivery or at your local CVS pharmacy for a 90-day supply. You can fill a maintenance medication at a retail pharmacy for a 30-day supply at the retail copay up to three times. After three, additional 30-day refills are subject to an additional $10 charge. Your doctor or pharmacist can assist you in changing to a 90-day supply through home delivery or to your local CVS store, which is not subject to the additional charge.

Express Scripts Drug Quantity Management

Drug Quantity Management (DQM) is a program designed to provide the medication you need for your good health while making sure you receive the amount – or quantity – considered safe. This gives you the right amount to take the daily dose considered safe and effective, according to guidelines from the U.S. Food & Drug Administration (FDA).
Prescription Drug Coverage

Drug quantity management helps save money in two different ways. First, if your prescription is available in different strengths, you may be able to take one dose of a higher strength instead of two or more of a lower strength. For example, you might be taking two 20 mg pills once a day. With your doctor’s approval, you could get a higher strength pill. Instead of taking two 20 mg pills once a day, you could take a 40 mg pill once a day. Second, the program helps to minimize the amount of extra supplies that you may accumulate over time.

Step Therapy

The university is always working to find ways to provide better prescription coverage while managing the rising costs of prescription medications.

The step therapy program is designed for patients with certain conditions that require them to take medications regularly. In this program, the medication therapy for a medical condition begins with the most cost-effective medication, and progresses to other more costly therapies should the initial medication not provide adequate therapeutic benefit.

The program’s aim is to help you choose a medication that is proven safe and effective, while getting it at the lowest possible cost. By using the most cost-effective first line medications you will not only save money, but the university and your colleagues save as well; helping to ensure that AU can continue to provide excellent coverage for you and your family.

If it is documented in your prescription drug history that you had previously tried a generic medication and it was not effective, you will not be affected by this program.

Kaiser Permanente also has this program in place.

How Does Step Therapy Work?

In step therapy, medications are grouped into categories.

Step One
First Line Medications: mostly generic medications proven safe, effective, and affordable. These medications are to be tried first.

Step Two
Second Line Medications: mostly higher costing brand name medications.

Step therapy is a process to ensure you are receiving a cost effective therapy. You will first try a recognized first line medication (Step One) before approval of a more costly and complex therapy is approved (Step Two). If the Step One therapy does not provide you with the therapeutic benefit desired, your physician may write a prescription for a second line medication. Generally, second line medications require the usage and failure of a first line medication before coverage. The step therapy approach to care is a way to provide you with savings without compromising your quality of care.

Certain chronic and non-chronic drug classes are subject to step therapy. For example, step therapy medication classes include cholesterol, acne, antidepressants, acid reflux, and anti-inflammatories. If your physician writes a new prescription for a medication that is part of the step therapy program, and the medication is not already part of your documented prescription drug history, your physician will need to write you a prescription for a first line medication. You may request that your pharmacist call the doctor for you and ask them to change to a first line medication; or have your physician submit a prior authorization request for your current prescription before you can continue to receive coverage for the medication. A prior authorization is a request to the physician to document why you cannot take a first line medication and must use a second line medication. You or your physician can begin the prior authorization process by calling Express Scripts at (877) 486-5984.

Always talk to your doctor before discontinuing or changing any medication. Ask your pharmacist or doctor about first line medications and discuss the step therapy medications on your benefit plan.

Excluded Medications

Excluded medications are not covered under the Express Scripts plan. Each of the excluded drugs have 1-5 alternatives covered under the plan that you can discuss with your doctor. If you choose to receive an excluded medication, you will be responsible for the full cost of the prescription. Excluded prescriptions are also not applicable toward the out-of-pocket maximum.

CuraScript/Accredo

Certain specialty prescriptions will be required to be filled by CuraScript/Accredo. There are some specialty medications that are not subject to this requirement. Contact Express Scripts with any questions at (877) 486-5984.
### Dental Coverage

American University offers you and your eligible dependents a choice between two dental plans from Delta Dental to help pay for many of the dental expenses you and your family incur.

#### Cost

AU contributes to the cost of your dental coverage (25% for individual and 20% for individual plus one and family coverage). Your cost for dental coverage is deducted from your pay on a pre-tax basis. Insurance premiums effective January 1, 2019, are shown on page 7 of this guide.

#### Coverage Levels

When you enroll, you will be able to elect one of the following coverage levels:
- Individual
- Individual plus one
- Family

During open enrollment, you may:
- Enroll in one of the dental plans to have dental coverage in 2019: Basic or Comprehensive
- Drop coverage
- Add or remove dependents (i.e., change your coverage level)

If you do not enroll for coverage during open enrollment, or if you elect to cancel your coverage, you may not enroll until a future open enrollment except as summarized in the “Making Changes During the Year” section on page 6.

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**Delta Dental**

Group Number: 03371  
Customer Service: (800) 932-0783  
www.deltadentalins.com

We offer two Delta Dental plan options: Basic and Comprehensive.

The Basic Plan covers screenings, cleanings, fillings, and periodontics, and is available for a lower monthly cost. For the Basic Plan you must choose a dentist who is in the Delta Dental PPO network.

The Comprehensive Plan (see chart on page 17) helps you pay for most necessary dental services and supplies, including orthodontia. PPO, Premier, and out-of-network dentists are covered in the Comprehensive Plan.

The following summaries are for general information only. Since exclusions, dollar, frequency, and age limitations apply, you should refer to the specific plan documents for detailed information. The benefits schedules reflect amounts paid by the plan based on the allowed benefit (see chart on page 17).

---

**Delta Dental Basic Dental Summary Chart: Plan Features**

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>PPO DENTISTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible*</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>$150</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td>Diagnostic and Preventive Services</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>(cleaning, x-rays, sealants, fluoride</td>
<td></td>
</tr>
<tr>
<td>treatment†, space maintainers)</td>
<td></td>
</tr>
<tr>
<td>Basic Restorative (fillings and simple</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>extractions), Oral Surgery, Endodontics,</td>
<td></td>
</tr>
<tr>
<td>and Periodontal services</td>
<td></td>
</tr>
</tbody>
</table>

*Waived for diagnostic and preventive benefits.  
†Fluoride treatment is covered only for children up to age 19.

Limitations or waiting periods may apply for some benefits. Reimbursement is based on PPO contracted fees for PPO dentists. Benefits are not covered if you visit a non-PPO dentist.

Regular dental visits may result in the early diagnosis and treatment of chronic diseases that have a better chance for a successful outcome. Gum disease is often linked to complications for diabetes, heart disease, stroke, preterm birth, and other health issues.
### Delta Dental Comprehensive Dental Summary Chart: Plan Coverage

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO DENTISTS</th>
<th>DELTA DENTAL PREMIER® AND NON-PPO DENTISTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td><strong>Plan Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,500 per person</td>
<td></td>
</tr>
<tr>
<td>Orthodontia Lifetime Maximum</td>
<td>$1,000 per person</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic and Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylaxis (cleaning)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride treatment†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic and Restorative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Extraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery, Endodontics, and Denture Repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incisions, excisions, surgical removal of tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denture repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major Restorative, Periodontics, and Prosthodontics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridges, crowns, inlays, and onlays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults and Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How Your Choice of Provider Affects Your Out-of-Pocket Cost in the Delta Dental Comprehensive Plan</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example</th>
<th>PPO</th>
<th>PREMIER</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider's charge for restorative service</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Plan's allowable charge (negotiated rate)</td>
<td>$70</td>
<td>$80</td>
<td>NA</td>
</tr>
<tr>
<td>Delta Dental pays (allowed benefit % of PPO rate)</td>
<td>$70 x 90% = $63</td>
<td>$70 x 80% = $56</td>
<td>$70 x 80% = $56</td>
</tr>
<tr>
<td>Employee pays (Dentist's negotiated rate or out-of-network charge less Delta Dental's payment)</td>
<td>$70 - $63 = $7</td>
<td>$80 - $56 = $24</td>
<td>$100 - $56 = $44</td>
</tr>
</tbody>
</table>

*This example assumes that you have met the plan's annual deductible and have not exceeded the annual plan maximum. The rates are for illustrative purposes only and do not reflect actual service amounts or allowable charges.

### Finding a Dentist/Confirming Your Dentist's Participation

The Basic Plan requires that you choose a PPO network dentist. Please contact your dentist's office to confirm that they are a participating Delta Dental PPO provider. The Comprehensive Plan lets you select any licensed dentist, but greater cost savings are realized when you select a dentist who participates in the Delta Dental PPO or Premier network. To find a participating dentist, check your benefits, review the plan, or print dental ID cards online, visit www.deltadentalins.com. If you have questions about your dental benefits, contact Delta Dental at (800) 932-0783.

### Predetermination of Dental Benefits

If your dental care will be extensive, ask your dentist to complete and submit a claim form to Delta Dental for a predetermination of benefits. Delta Dental will advise you exactly what procedures are covered, the amount that will be paid toward the treatment, and your financial responsibility.
Flexible Spending Accounts

Lower Your Taxes with Flexible Spending Accounts

You can set aside money in a Flexible Spending Account (FSA) before taxes are deducted to pay for certain health and dependent care expenses, lowering your taxable income and increasing your take-home pay. You can use the ConnectYourCare payment card to pay for eligible expenses or prepay and file a claim online at www.connectyourcare.com. Keep your receipts as it may be requested to verify expense eligibility by ConnectYourCare or the IRS. Only expenses for services incurred during the plan year and grace period while you are actively employed are eligible for reimbursement from your accounts.

You may elect to participate in either or both the health care flexible spending account or the dependent care flexible spending account; however, money cannot be transferred between the accounts. For example, money in your health care flexible spending account may not be used to pay for dependent care expenses.

Open Enrollment Elections

FSA participation does not continue automatically from year-to-year. You must elect your flexible spending accounts to continue them in 2019.

During open enrollment, you may:

• Elect to contribute up to $2,650* to the health care FSA
• Elect to contribute up to $5,000 to the dependent care FSA ($2,500 if you are married and filing separate tax returns)

If you do not enroll or re-enroll:

• You will not participate in the health care FSA during 2019 except as summarized in the “Making Changes During the Year” section on page 6.
• You will not participate in the dependent care FSA during 2019 except as summarized in the “Making Changes During the Year” section on page 6.

Cost

Your cost is based on the contribution amounts you elect. You pay a small monthly fee ($1.45).

The annual maximum amount you may elect is $2,650* for the health care FSA and up to $5,000 for the dependent care FSA ($2,500 if you are married and filing separate tax returns).

When estimating your dependent care expenses, remember you may not have expenses for weeks of vacation, illness, or other times your dependent receives free care. Additionally, please note that you may use dependent care only for children up to age 13.

*At the time of printing of this benefits guide, the IRS had not yet released the 2019 benefits limits.

How Do FSAs Work?

• You select the amount you want to contribute based on expenses you anticipate through March 15, 2020 (which includes the 2.5 month grace period). Estimate carefully because you cannot recover money left in the account at the end of the plan year and grace period.
• Your contributions are deducted before federal income or Social Security taxes are withheld.

Changing Your FSA Contributions

Participating in an FSA is a plan year commitment. During the year, you cannot change the amount you contribute, start participating, or stop making contributions unless you have a qualifying life event. Generally speaking, you cannot lower your contributions. Qualifying life events are listed in the “Making Changes During the Year” section on page 6 of this guide. You can make an election change in
Flexible Spending Accounts

the dependent care flexible spending account (but not the health care flexible spending account) due to a change in the cost of dependent care providers.

Health Care Flexible Spending Account

The health care flexible spending account helps you pay for medical, dental, and vision expenses that are not covered or fully reimbursed by your other benefit plans (for example, copayments, coinsurance amounts, deductibles, and amounts above benefit maximums). You may submit reimbursement requests for health care expenses regardless of the balance in your account. You will be reimbursed for the entire amount of the eligible expenses you have paid up to your annual contribution amount – even before the full contribution has been deducted from your paychecks.

What are Flexible Spending Accounts (FSAs)?

FSAs are accounts you fund with pre-tax money withheld from your paycheck to pay for eligible health and dependent care expenses that are not reimbursed from any other source. AU offers two accounts: health care and dependent care flexible spending accounts.

Examples of eligible expenses include:
- Deductibles, copayments, and coinsurance for medical, dental, vision, or prescriptions
- Other eligible medical, dental, vision, and prescription expenses not covered under a health plan
- Diabetic testing supplies

Examples of ineligible expenses include:
- Premiums you pay for health coverage if they already are deducted from your pay on a pre-tax basis
- Cosmetic surgery (except for covered reconstructive surgery, such as after a mastectomy)
- Teeth bleaching or whitening
- Expenses for over-the-counter medications without a prescription

For a complete listing of eligible health care flexible spending expenses, visit www.connectyourcare.com.

To register as a new user on the site, you will need your social security number, date of birth, an email address, and your payment card number. If you do not have a payment card, just check the box stating that you do not have a card associated with your account.

Keep in mind that a health care flexible spending account is for eligible health care expenses for you and all of the dependents you claim on your federal tax return – not just those dependents covered under a university-sponsored medical plan.

Over the counter medications are not covered by FSAs

Expenses for over-the-counter medications are not eligible for reimbursement. There is one exception: prescriptions for an over-the-counter medication may be covered.

Contact ConnectYourCare for more details.

Flexible Spending Account Limits

- The health care FSA limit is $2,650*.
- The dependent care FSA limit is $5,000 ($2,500 if married and filing taxes separately).

*At the time of printing of this benefits guide, the IRS had not yet released the 2019 benefits limits.

Commonly Asked Questions

I’m not in the AU medical or dental plans. Can I enroll in the health care spending account through AU?

Yes. You are eligible to enroll in our health care flexible spending account even if you are not in the medical or dental plans.

Can I use the health care flexible spending account to reimburse myself for medical insurance premiums?

No. If you are enrolled in one of our medical plans, you pay these premiums with pre-tax dollars and cannot use the health care FSA to pay your premiums.

How do the deductions calculated?

Your deduction is based on your annual election and your pay frequency. If you are paid biweekly, then your deduction will be 1/26 of your annual election. If you are paid monthly, your deduction will be 1/12 of your annual election. The deductions for these plans are made on a pre-tax basis. For elections starting after the beginning of the year, deductions are based on the remaining number of pay periods in the year.

When will I be able to access the pre-tax monies I set aside for my health care flexible spending account?

For your health care FSA, you will have access to your pre-tax monies at any time during the year, regardless of whether the money has been deducted from your paycheck.

2019 Know Your Benefits Enrollment Guide: Benefit Decision Points | 19
Flexible Spending Accounts

Dependent Care Flexible Spending Account

The dependent care flexible spending account reimburses you for eligible dependent care expenses (for example, day care and elder care) that enable you (and your spouse, if you are married) to work. If your account currently does not hold sufficient funds to cover the entire reimbursement, you receive a partial payment. Additional reimbursements are issued automatically after contributions from your next paycheck have been added to the account. Special rules apply to spouses who are full-time students or incapable of self-care. Contact your tax advisor for additional guidance.

Eligible expenses include:
- Care provided inside or outside your home
- Day care provided at a licensed facility
- Day camp (up to age 13)

Expenses that are not eligible include:
- School tuition for dependents (except for preschool and AU’s Child Development Center)
- Payments to a spouse or child under age 19
- Child support payments
- Personal expenses for dependents
- Overnight camp

Expenses reimbursed under this plan may not be claimed as a federal tax credit on your tax return. Consult with a financial advisor to determine which tax-saving method is best for you.

How the FSA Payment Card Works

FSA participants automatically receive a payment card that allows direct access to FSA funds for eligible health care and dependent care expenses. You can use the card when you make eligible health care and dependent care purchases from most merchants who accept credit or debit cards. Because the card deducts funds directly from your FSA account to pay for services and supplies, it eliminates the wait for reimbursements. The card is offered at no additional charge to you and is not tied to or reported against your credit report.

Rules of the Road: Your FSA Payment Card

There are a few rules to know about using your card that will save you time and frustration. Here are some tips:

- When you incur an eligible expense, you may use your ConnectYourCare payment card to pay the provider right away.
- If you paid with the payment card, be sure to keep copies of all claims and receipts for seven years, as you do with all tax records. ConnectYourCare or the IRS may request the receipts to audit your account.
- You may use your payment card to exhaust funds when the charges are standard copayment amounts.
- Generally, ConnectYourCare may ask for documentation to support non-standard charges (charges other than deductible or coinsurance amounts) or charges that were not processed through a verification system (such as at Target, Walgreens, or CVS, whose systems verify the item’s eligibility).
- You may use your payment card to exhaust funds from your 2018 flexible spending accounts after December 31, 2018 through March 15, 2019.
- All 2018 flexible spending claims must be submitted to ConnectYourCare by April 30, 2019.
- New participants receive a ConnectYourCare FSA payment card within a few weeks of enrollment. If you have a PayFlex card from 2018, please discard it after December 31, 2018.

Dependent care FSA is not just for child care expenses

You will have access to your dependent care spending account funds as they accrue through the year. Under IRS guidelines, you can only be reimbursed for dependent care that has already taken place.

Adult day care and elder care are also considered eligible expenses as long as your adult dependent regularly spends at least eight hours each day in your home. Services can be provided at home by an eligible provider or in a dependent care center.
Flexible Spending Accounts

Commonly Asked Questions

When will I receive my payment card?
2019 FSA open enrollment participants can expect to receive a card at your home address by the end of December. Otherwise, payment cards take 15 days to process. You will receive one card. Additional cards for your dependents can be obtained online at www.connectyourcare.com or by contacting ConnectYourCare at (877) 292-4040.

Use your PayFlex card through December 31, 2018 and then use the ConnectYourCare payment card as of January 1, 2019.

Do I have to use my ConnectYourCare payment card?
No. Use of the card is optional. Traditional claim processing remains available and must be used for purchases from providers who do not accept debit or credit card payments or are not designated as eligible merchants.

How does the card know which expenses are eligible and which are not?
Each merchant or provider accepting a payment card is assigned a merchant category code. There are more than 500 codes and the card only accepts codes related to eligible expenses under health care and dependent care FSAs. The card will deny merchant category codes that have not been programmed on the card.

Although these safeguards are in place, you are fully responsible for ensuring that only eligible expenses are paid using the card. Contact ConnectYourCare if you experience problems using your card for eligible expenses. Additionally, charges at a physician’s office, other than the standard $20 or $40 copayment amounts, may trigger a request from ConnectYourCare for documentation to support the charge.

What do I do if my card is lost or stolen?
Immediately call ConnectYourCare at (877) 292-4040 to deactivate your card. You may order a replacement card at no additional cost.

When I use the card, do I need to submit my receipt?
Not necessarily. ConnectYourCare may request copies of your receipts to audit your account. They recommend you retain all receipts and Explanations of Benefits with your tax records in case they are requested by ConnectYourCare or the IRS.

Will my transaction be denied if I don’t have enough money in my account to cover the expense?
Yes. Transactions for any amount that is greater than your allowable balance will be denied. Your health care FSA balance is your annual election amount less any reimbursements that have already been paid. Your dependent care spending account balance is the amount in your account at the time your claim is processed (contributions made minus any reimbursements paid previously).

If I receive more than I contributed to the medical spending account, am I required to “repay” this amount to AU?
No. If you receive a reimbursement for more than you contributed to the medical spending account, you will get to keep the amount you received in excess of the amount you funded.

Can I have my reimbursements deposited directly to my checking or savings account?
Yes. We recommend that you set up a direct deposit account for reimbursements. To complete a direct deposit form, go to www.connectyourcare.com. You may elect this direct deposit option at any time; you do not need to wait until the beginning of a new plan year.

What happens to my flexible spending accounts if I stop working full-time at AU?
If you stop working at AU full-time during the year, special rules apply. Eligible expenses must be incurred on or before your last date of work, and claims must be filed no later than April 30, 2019. You will be reimbursed for the amount of your eligible expenses up to your full annual election for the medical spending account for claims incurred through the termination date. For the dependent care spending account, you will be reimbursed only for the amount you contributed to that plan, which is often less than the annual election for employees terminating during the middle of a plan year. You may use dependent FSA funds through March 15, 2019 and submit claims to ConnectYourCare by April 30, 2019.

Special Note for 2018 FSA Participants with Balances on January 1, 2019.
There will be a two-week blackout period to access your 2018 FSA balances during January 1 - January 15 while we change FSA administrators. If you made 2019 FSA elections, you can use your new ConnectYourCare payment card during this period, but it will be accessing 2019 funds. You will have access to 2018 funds through ConnectYourCare after January 15, 2019.
Life and Accident Insurance

Life insurance protects and provides security for your family or other beneficiaries in the event of your terminal illness or death while you are still actively employed at American University. Your coverage amount will be paid to your beneficiary of record in the event of your death. You can view or update your beneficiary information on the myBenefits site.

If you wish to supplement the basic life and AD&D insurance amount, you may purchase additional voluntary coverage through the university.

- **Optional Life** - for you, your spouse or same- or opposite-sex domestic partner, and your dependent children
- **Personal Accident** - for you and your family

Basic Life and AD&D Insurance

The university offers basic life insurance in the amount of one (1) times your annual salary paid by the university.

If your death is due to a covered accident or injury, your beneficiary will receive an additional amount through accidental death and dismemberment (AD&D) coverage. AD&D coverage is equal to your basic life insurance coverage amount. AD&D benefits are payable if you pass away, lose a limb, or have a loss of speech, hearing, or eyesight because of a covered accident (either on or off the job) and the loss occurs within one year of the covered accident. The payable amount of your AD&D benefit depends on the type of loss. In the event of death due to an accident, your beneficiary may receive both your life and AD&D benefits.

Prudential Insurance

Group Number/Control Number: 52144
Evidence of Insurability Application Status: www.prudential.com/mystatus or (888) 257-0412

Cost

AU pays the entire cost of these benefits. There is no cost to you and enrollment is automatic. Your coverage is subject to actively-at-work requirements. Please note that the premium for life insurance coverage in excess of $50,000 is imputed income. The IRS requires that the value of the premium for life insurance benefits in excess of $50,000 for federal income tax purposes be subject to taxation.

Optional Life and Personal Accident Insurance Options

The optional life insurance complements your employer paid basic life insurance by providing you an option to purchase additional coverage in the event of your death. The coverage amount can be 1, 2, 3, 4, or 5 times your base salary. The maximum election for employee optional life is $1,500,000. You may purchase $10,000 - $100,000 in coverage for your spouse or domestic partner and/or $1,000 - $10,000 for your eligible dependent.

The life insurance coverage amount you elect for your spouse or domestic partner may not exceed the total amount of life insurance coverage you have for yourself (your total life insurance equals your basic life insurance coverage and optional life insurance coverage combined).

If I want additional life insurance, what is the maximum amount of life insurance for which I can apply?

You may apply for up to 5 times base salary or $1,500,000 (whichever is lower). Amounts above 4 times base salary or more than $600,000 are subject to medical review. If you are increasing by more than 1 times your salary or are newly applying for optional life insurance, you will need to undergo a medical review process. Visit the Life and Disability site under the Benefits section on www.american.edu/hr to obtain a Statement of Health form to initiate the process.

Do I automatically get life insurance?

Yes. Every full-time faculty and staff member gets 1 times their base salary which is fully paid for by the university.
Life and Accident Insurance

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>LEVELS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Basic Life Fully paid by the University</td>
<td>1 times base salary</td>
</tr>
<tr>
<td>Employee Optional Life Insurance Paid by the Employee</td>
<td>1, 2, 3, 4 or 5 times base salary</td>
</tr>
<tr>
<td>Spouse/Domestic Partner Optional Life Insurance Paid by the Employee</td>
<td>$10,000 to $100,000 in $10,000 increments</td>
</tr>
<tr>
<td>Dependent Optional Life Insurance Paid by the Employee</td>
<td>$1,000 to $10,000 in $1,000 increments</td>
</tr>
</tbody>
</table>

Optional Life Coverage Rates (Employee/Spouse/Domestic Partner)

<table>
<thead>
<tr>
<th>AGE</th>
<th>2019 RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 and under</td>
<td>$0.040</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.045</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.051</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.089</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.149</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.230</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.430</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.660</td>
</tr>
<tr>
<td>65+</td>
<td>$1.225</td>
</tr>
</tbody>
</table>

If you do not make an election during this open enrollment, your current life and accident benefit elections will carry over to 2019. This includes optional life and personal accident insurance elections for you and your family.

Although you may not increase your coverage after open enrollment unless you have a qualifying life event, you may decrease or drop any optional life insurance coverage at any time during the year.

Statement of Health

The Statement of Health (also known as Evidence of Insurability or proof of good health) is a questionnaire, to be completed by you and your physician, which provides some basic health information to the insurer. This information is used in the approval process for your request to enroll in, or increase, certain life insurance plans. The Statement of Health must be approved by the insurance company before coverage can become effective.

For optional life coverage, you will be required to furnish a Statement of Health for approval by the insurance company if you are electing coverage for amounts of 5 times your salary or $601,000 - $1,500,000, increasing your covered amount by more than one times your salary, electing coverage for the first time during open enrollment, or electing coverage for the first time due to a qualifying event. A Statement of Health is required for your spouse/domestic partner if you are electing coverage for amounts of $20,000 - $100,000, increasing your covered amount by more than $10,000, electing coverage for the first time during open enrollment, or electing coverage for the first time due to a qualifying event (if due to marriage, you may elect up to $10,000 coverage without providing a Statement of Health).

To submit a Statement of Health, print and complete the form and mail or fax it to Prudential at the address or fax number that appears on the form. Prudential will make its determination based on your medical information and may request additional medical information or tests. Once reviewed and approved, Prudential will send a letter to your home confirming coverage.
Life and Accident Insurance

How to calculate life/personal accident insurance costs for you and your spouse/domestic partner

To calculate your cost, complete the following by selecting your coverage amount and rate (based on your age).

<table>
<thead>
<tr>
<th>Elected Coverage</th>
<th>Increment</th>
<th>Insurance Rate</th>
<th>Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$1,000</td>
<td>$0.051</td>
<td>$5.10</td>
</tr>
<tr>
<td>Spouse/Domestic Partner</td>
<td>$1,000</td>
<td>$0.051</td>
<td>$5.10</td>
</tr>
</tbody>
</table>

Total Monthly Cost = $5.10

Sample Calculation

Clawed Z. Eagle is 36 years old and has a salary of $50,000. He is electing optional life coverage of $100,000 (2 times his salary). Clawed reviewed the optional insurance rates and notes his insurance rate in the table is $0.051. He plugs in the information in the calculation below. Clawed calculated that the monthly cost of electing $100,000 of optional life insurance is $5.10 per month. Clawed notes that the cost per month is the same to enroll his wife in the plan (see rates on the previous page).

<table>
<thead>
<tr>
<th>Elected Coverage</th>
<th>Increment</th>
<th>Insurance Rate</th>
<th>Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee (Clawed Z. Eagle)</td>
<td>$100,000</td>
<td>$0.051</td>
<td>$5.10</td>
</tr>
</tbody>
</table>

Total Monthly Cost = $5.10

Dependent Life Coverage

You may also purchase life insurance for your eligible dependent children from live birth to age 26.

What is the Cost of Dependent Life Coverage?

The monthly cost corresponds to the coverage you elect for dependent child coverage from live birth to age 26.

Optional Life (Dependent Child)

<table>
<thead>
<tr>
<th>AMOUNT</th>
<th>2019 COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$0.114</td>
</tr>
<tr>
<td>$2,000</td>
<td>$0.228</td>
</tr>
<tr>
<td>$3,000</td>
<td>$0.342</td>
</tr>
<tr>
<td>$4,000</td>
<td>$0.456</td>
</tr>
<tr>
<td>$5,000</td>
<td>$0.570</td>
</tr>
<tr>
<td>$6,000</td>
<td>$0.684</td>
</tr>
<tr>
<td>$7,000</td>
<td>$0.798</td>
</tr>
<tr>
<td>$8,000</td>
<td>$0.912</td>
</tr>
<tr>
<td>$9,000</td>
<td>$1.026</td>
</tr>
<tr>
<td>$10,000</td>
<td>$1.140</td>
</tr>
</tbody>
</table>
Life and Accident Insurance

Optional Personal Accident Insurance

The optional personal accident insurance complements your optional life coverage in the event of death due to an accident or covered disabling injury. This coverage is in addition to your life insurance and can help replace lost income and lessen the impact of costs associated with serious injuries. The coverage amount can be 1, 2, 3, 4, 5, 6, 7, 8, 9, or 10 times your annual earnings. If the coverage amount is not a multiple of $1,000, then it is rounded to the next higher multiple of $1,000. The maximum election is $500,000. This summary is provided for general information only since exclusions and limitations apply. For more details and information about family coverage, refer to the Faculty/Staff Benefits Manual.

Beneficiary Designations

A primary beneficiary is defined as the person, organization, trust, or entity you name to receive any benefits if you die.

A contingent beneficiary is defined as the person, organization, trust, or entity you name to receive any benefits if the primary beneficiary is deceased.

Keep in mind that changes in your family situation (such as marriage, divorce, birth, or adoption) do not automatically alter or revoke your beneficiary designation. Therefore, it is important that you review your beneficiary designation from time to time.

Updates to life and accident beneficiary information can be made at any time by making changes on the myBenefits online enrollment site.

Optional AD&D

<table>
<thead>
<tr>
<th>COVERAGE LEVEL</th>
<th>2019 RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$0.015</td>
</tr>
<tr>
<td>Family</td>
<td>$0.025</td>
</tr>
</tbody>
</table>

Optional AD&D Calculation

<table>
<thead>
<tr>
<th>Coverage Amount</th>
<th>Increment</th>
<th>Insurance Rate</th>
<th>Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$</td>
<td>$1,000</td>
<td>0.015</td>
</tr>
<tr>
<td>Family</td>
<td>$</td>
<td>$1,000</td>
<td>0.025</td>
</tr>
</tbody>
</table>

Total Monthly Cost = $
Legal Plan

**Hyatt Legal Plans**

**MetLaw® Group Legal Coverage**

Faculty and staff have an option to select legal coverage through Hyatt Legal's MetLaw Plan. This plan provides a variety of services to help you protect your family, finances, and future. You have access to network attorneys who provide legal services for covered events (see the list in the next column). The plan covers representation for many personal legal services for you and your eligible dependents (eligible dependents are your spouse and unmarried dependent children*). You may receive office consultations and/or telephone advice for virtually any personal legal matter, and as long as it is not specifically excluded, you will receive the opportunity to discuss that matter with an attorney.

Hyatt Legal’s MetLaw Plan provides you with telephone and office consultations for an unlimited number of matters with the attorney of your choice. During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options, and recommend a course of action.

Trials for covered matters are covered from beginning to end, regardless of length, when using a network attorney.

*Eligible dependent children are under the age of 26 and are unmarried or disabled.

**Hyatt Legal Plans**

Customer Service: (800) 821-6400

www.legalplans.com

Access code: GetLaw

**How the Plan Works**

Once enrolled, to use the legal plan, call Hyatt Legal’s Client Service Center at (800) 821-6400. Your Social Security Number is your identifier for you and your dependents. A representative will verify your eligibility; make an initial determination of coverage; give you a case number; provide you with the telephone number of a plan attorney most convenient to you; and answer any questions you have about the plan. You may also use the plan by visiting the Hyatt Legal Plans website at www.legalplans.com.

**Covered Legal Services**

- Preparation of wills, living wills, and living trusts
- Purchase, sale, and refinancing primary residence
- Debt collection defense
- LifeStages® Identity Management Services
- Traffic ticket defense (no DUI/DWI)
- Personal bankruptcy
- Civil litigation defense
- Uncontested adoption, guardianship, conservatorships
- Protection from domestic violence
- Tenant negotiations and eviction defense (tenant only)
- ElderLaw (for issues related to your parents and Medicare, Medicaid, nursing home arrangements, etc.)
- Preparation of Powers of Attorney, affidavits, demand letters, etc.
- Tax audits and property tax assessments
- Juvenile Court defense
- Name change and premarital agreement
- Review and preparation of personal legal documents
- Consumer protections and small claims assistance
- Restoration of driving privilege
- Boundary-title disputes and zoning applications
- School hearings
- Pet liabilities

**Note:** You may be responsible for certain fees (i.e., filing fees) in connection with these covered services.
New for 2019!

**LifeStages® Identity Management Services**

LifeStages Identity Management Services from Hyatt Legal Plans keep pace with emerging identity threats. If you ever find yourself faced with identity theft worries, you and your family can get help from a dedicated fraud specialist from CyberScout (formerly IDT911), the nation's premier provider of identity services. The specialist will handle the recovery process behind the scenes by placing fraud alerts, calling creditors, and sticking with you for as long as it takes to restore your good name and peace of mind.

*Identity protection services are available to a spouse and/or a child of the member, who is under the age of 26 and is unmarried or disabled. CyberScout is not a corporate affiliate of Hyatt Legal Plans.

**Excluded Legal Services**

No services, not even a consultation, can be provided for the following:

- Employment-related matters, including company or statutory benefits
- Matters involving American University, MetLife and affiliates, and plan attorneys
- Matters in which there is a conflict of interest between you and your spouse or dependents in which case services are excluded for the spouse and dependents
- Divorce proceedings
- Appeals and class actions
- Farm and business matters, including rental issues when you are the landlord
- Patent, trademark, and copyright matters
- Third party costs like fines, filing fees, or court fees
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to you becoming eligible for plan benefits

**Employee Eligibility**

- Full-time faculty and staff are eligible as of the first of the month following date of hire.
- Changes can be made only during open enrollment. *Once enrolled in the legal plan, faculty and staff may not drop coverage until the next open enrollment.*

**Out-of-Network Benefits**

You also can access services from outside the network of attorneys. There is a separate schedule for reimbursement for these services. Once enrolled, you would be able to call Hyatt Legal’s Client Service Center for a fee reimbursement package for use with a non-plan attorney.
Retirement Plan

The most popular benefit at AU is the 403(b) Retirement Plan, which allows you to make contributions immediately to your retirement savings, and after meeting certain eligibility requirements, receive a 2-to-1 match, all of which can help you reach your financial goals for retirement. You save money on current income taxes by deferring some of your current compensation into a retirement plan account or save money on future income taxes through Roth after-tax contributions. If you are a new hire, you are automatically enrolled to receive the university’s 2-to-1 match when you become eligible to receive the match.

You can make changes to your contributions and asset allocations at any time; you do not need to wait until open enrollment.

Contribute Now

You do not have to wait to begin saving for your future. You can contribute to the Plan immediately, regardless of age and service. We will contact you when you become eligible for the match so you can maximize your benefit. If you have a year of service at another 501(c)(3) non-profit or university, you may be eligible for a waiver of the one-year waiting period. Please contact Human Resources at x2591 for more details.

Eligibility for AU’s 2-to-1 Match on Your Contributions

You are eligible to receive the 2-to-1 matching contributions if you have worked at AU for 12 consecutive months, are normally scheduled to work at least 20 hours per week, and worked for at least 1,000 hours during that 12-month period. The first five percent (5%) of your contributions are matched 2-to-1 by the university once you become eligible for the match, for a total contribution of up to 15%.

<table>
<thead>
<tr>
<th>IF YOU CONTRIBUTE</th>
<th>AU CONTRIBUTES</th>
<th>TOTAL CONTRIBUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% of Regular Salary</td>
<td>2% of Regular Salary</td>
<td>3% of Regular Salary</td>
</tr>
<tr>
<td>2% of Regular Salary</td>
<td>4% of Regular Salary</td>
<td>6% of Regular Salary</td>
</tr>
<tr>
<td>3% of Regular Salary</td>
<td>6% of Regular Salary</td>
<td>9% of Regular Salary</td>
</tr>
<tr>
<td>4% of Regular Salary</td>
<td>8% of Regular Salary</td>
<td>12% of Regular Salary</td>
</tr>
<tr>
<td>5% of Regular Salary</td>
<td>10% of Regular Salary</td>
<td>15% of Regular Salary</td>
</tr>
</tbody>
</table>

Fidelity Investments

Plan Number: 56730
Customer Service: (800) 343-0860
www.fidelity.com

TIAA

Plan ID: 103175
Customer Service: (800) 842-2252
www.tiaa.org

Your Matching Contributions

If you are automatically enrolled, your initial payroll deferral amount will be 1% of your basic annual salary and matched with a 2% contribution from the university, which will be invested in a target date fund with a maturity closest to your expected retirement date through Fidelity Investments. Automatic payroll deductions will be taken on a pre-tax basis.

You may change your rate of participation or your investment service provider (TIAA or Fidelity) at any time on the online retirement site, hosted by Fidelity Investments. You can access this site through the myAU portal (Work@AU > Benefits: myBenefits – Retirement) or by going to www.netbenefits.com/au.

We encourage you to take an active role in the Plan and choose a contribution rate and investment options that are appropriate for you. Through automatic payroll deductions, you may contribute any percent of your basic annual salary, up to 100%, on a pre-tax basis up to annual IRS dollar limits. If you have reached age 50 or will reach age 50 during the calendar year January 1 - December 31 and are making the maximum plan or IRS pre-tax contribution, you may make an additional “catch-up” contribution.
Retirement Plan

Retirement Plan Fund Line-up

The retirement fund line-up, available through both Fidelity and TIAA is as follows:

**Tier 1 - Lifecycle Funds**
Tier 1 includes all-in-one investments that may be more appropriate for individuals who want a diversified investment approach in a single fund. Target date funds offer a single choice for your retirement investments based on your expected year of retirement.

**Tier 2 - Passive Management (Index Funds)**
Tier 2 may be more appropriate for those who want a more active role in determining how they want their retirement dollars allocated. Commonly known as “index funds,” passively managed funds do not seek to beat their benchmark but rather to match the benchmark’s performance. Since the investment decisions made by the fund manager are made to simply mirror each fund’s particular index, passively managed funds are designed to provide a broad selection of investments at relatively low cost.

**Tier 3 - Active Management**
Tier 3 may be more appropriate for those who want a more active role in determining how they want their retirement dollars allocated. Actively managed funds seek to beat or exceed their benchmark. Because managing the fund often requires a great deal of research and the transactions within the fund are often more frequent, expenses tend to be higher than those of passively managed funds.

**Tier 4 – Brokerage Window**
For those desiring the most investment flexibility and choice, Tier 4 offers a self-directed brokerage option, which gives you access to an extended range of mutual funds. Unlike Tier 1 through 3 funds, Tier 4 funds are not monitored by the university’s Retirement Plan Investment Advisory Committee.

**IRS Limits**
Tax law limits the amount you can contribute on a pre-tax or Roth after-tax basis to the Plan each year. Tax law also limits the amount of compensation that is considered eligible for the Plan. You cannot defer any portion of your compensation above that limit into the Plan. For more information about these limits, please visit the Benefits Retirement section on www.american.edu/hr.

Vesting
Vesting refers to the portion of your Plan account balance to which you are entitled under the Plan rules. You are immediately 100% vested in the Plan.

Tax Considerations
You pay no taxes on your pre-tax contributions, university matching contributions, or investment returns until you withdraw funds from the Plan. However, FICA (Social Security and Medicare) taxes are withheld before deferrals to the Plan are made.

Roth after-tax contributions and related earnings may be withdrawn from the Plan tax-free if taken at least five tax years after your first Roth contribution and you are at least age 59-1/2, become disabled, or die.

Retire Well
American University’s pre-retirement program provides education and resources for everyone, regardless of where you are in your career. The Retire Well program can help you articulate your vision of retirement, consider factors that may impact your satisfaction in retirement, and provide tools to design a strategy for a successful retirement. Visit the Retire Well site for the current session schedule and resources at www.american.edu/hr/retire-well.

**Schedule a one-on-one consultation with a Fidelity or TIAA financial consultant**

We encourage everyone to schedule a one-on-one appointment with our Fidelity and TIAA consultants, regardless of whether you are in the early, mid, or late phase of your career. The consultants are on-site at AU twice a month and are willing to discuss all aspects of financial planning.

To schedule an appointment with our Fidelity representative, call (800) 642 7131 or visit getguidance.fidelity.com.

To schedule an appointment with our TIAA representative, call (800) 732-8353 or visit www.tiaa.org/schedulenow.
AhealthyU Wellness Program

AhealthyU

Health & Wellness Programs and Services

AU created AhealthyU to support the health and well-being of its faculty and staff through integrated programs, education, and resources that encourages positive daily habits that fit your goals and lifestyle. AhealthyU offers a holistic approach to wellness that focuses on four pillars to help you become healthier and happier.

Four Pillars of Wellness

- **Physical**: Maintain overall physical health and engage in appropriate physical activity (e.g., stamina, strength, flexibility, healthy body composition).
- **Emotional**: Have a positive self-concept, deal constructively with your feelings, and develop positive qualities (e.g., optimism, trust, self-confidence, determination, persistence, dedication).
- **Intellectual**: Pursue and retain knowledge, think critically about issues, make sound decisions, identify problems, and find solutions (e.g., common sense, creativity, curiosity).
- **Spiritual**: Develop a set of beliefs, principles, or values that give meaning or purpose to your life; to develop faith in something beyond yourself (e.g., religious faith, service to others).

AhealthyU provides you with the tools you need to make the best possible choices and to achieve your goals.

Points to AhealthyU

Participate in AhealthyU programs and activities throughout the year and collect game stamps that can be redeemed for prizes. Visit the website for game information and activities award chart.

www.american.edu/Points

AhealthyU Group Exercise Classes

AhealthyU has partnered with the AU Recreational Sports & Fitness Department to offer group exercise classes exclusively for faculty and staff. Find some inner peace with lunchtime yoga, build strength with Pilates or Barre, or move to the beat in an evening Zumba class. Classes are no-cost for fitness center members and open to non-members for a small per class drop-in fee. Classes are held at the Jacobs and Cassell fitness centers as well as several off-campus locations. Classes held at off-campus locations are offered at no-cost.

www.american.edu/Fitness

Luncheon Learn Wellness Workshop Series

Each month, we will visit a different dimension of wellness to support you in your goals for healthy living. A complimentary light lunch is provided. Workshops will be announced on the website below. Workshops include *Get Unstuck and Create Goals that Stick*, *Fight Off Disease with the Power Plate*, and *Natural Solutions for a Stress-Free Winter*.

www.american.edu/hr/luncheon-learns.cfm

Cooking Demonstrations with AU Dining

Throughout the year, AhealthyU partners with AU Dining for a 45-minute cooking demonstration. A light lunch is provided with samples of the chef's creation. Demonstrations will be announced on the website below. Past demos have included *Scary Good Treats* and *Back to Basics*.

www.american.edu/Workshops

Start your fitness plan with AhealthyU!

If you have been thinking about increasing your fitness routine, AhealthyU is here to help! From yoga to Zumba to pedometer challenges to Couch to 5K, we have got a program that will help you get started. Visit www.american.edu/AhealthyU.
AhealthyU Wellness Program

Couch to 5K and 5K to 10K Training

The beginners and intermediate running programs for AU faculty and staff will take you from the couch to the finish line of a 5K in eight weeks or 10K in ten weeks. Prepare to run a 5K or 10K race in this three-day-per-week training program. You will start with intervals of walking and jogging to increase your endurance. The training group meets twice per week on campus and participants are encouraged to train once per week on their own. Registration fee includes training, wicking t-shirt, and race entry fee. The Couch to 5K and 5K to 10K training program kicks off twice each year at the beginning of each semester.

www.american.edu/hr/5k.cfm

Farmers Market

AU Farmers Market features locally grown produce, hearth-baked breads, freshly roasted coffee, plants, and more. Rain or shine during the spring and fall, Wednesdays on the Quad.

www.american.edu/hr/farm.cfm

Financial Wellness Programs

In partnership with consultants from PricewaterhouseCoopers, TIAA, and Fidelity, AhealthyU offers events and workshops to help you meet your financial goals, regardless of whether you are in your early, mid, or late stage of your career.

Past sessions have included:
- Investing
- Estate Planning
- Financial Planning
- Personal Budgeting
- Pre-retirement and Retirement Planning

www.american.edu/hr/AhealthyU/financialwellness.cfm

Flu Shots

Each fall, AhealthyU brings no-cost flu shots to campus for all faculty and staff.

If you are enrolled in one of AU’s medical plans, you can also get your flu shot at your doctor. Flu shots are covered at 100% at your physician’s office through your preventive screenings benefit.

www.american.edu/hr/AhealthyU/Flu-shots.cfm

Gym Memberships (Discounted) On- and Off-site

Low-cost memberships are available for faculty and staff through AU Recreational Sports & Fitness and a number of off-site, local gyms.

AU’s Jacobs and Cassell Fitness Centers

As part of Recreational Sports & Fitness, Jacobs Fitness Center and Cassell Fitness Center are AU’s on-site fitness facilities. You will find state-of-the-art fitness equipment, an indoor pool, lockers and sport equipment rentals. They also offer group exercise classes, instructional programs, and personal training. Additionally, Recreational Sports & Fitness offers intramural sports for AU faculty, staff, and students. There are no initiation fees, no contracts, and no obligations. Payroll deduction available for full-time faculty and staff. $35 fitness assessments are complimentary, courtesy of AhealthyU.

www.american.edu/recfit

Off-site Discounted Gym Memberships

- Sport & Health

For more information, email ahealthyu@american.edu.

Other Gym Memberships

As a member of Kaiser Permanente or CareFirst, you have access to discounted gym memberships at area facilities. Visit their websites for more information.

Health Assessments

Create a plan for healthy living by completing the confidential, online health assessment. Upon completion, you will receive a comprehensive, personalized report outlining your current health status, areas for improvement, and potential next steps. You will also have access to an entire portal filled with healthy tools and trackers to keep you on target. Additionally, AhealthyU will reward you for completing your health assessment with $10 in EagleBucks or an AhealthyU water bottle through the Points to AhealthyU program.

Visit www.american.edu/healthyliving for more information on the privacy and confidentiality of your health information as it relates to this service.

*$10 reward is subject to tax.
AhealthyU Wellness Programs

MOVE Fitness Challenge

Each fall, this one month challenge is designed to encourage an active lifestyle that tracks all activities using steps or minutes. Besides the usual fitness activities of walking, swimming, and biking, MOVE also tracks activities such as gardening and cleaning. A grand prize is awarded to the top five highest scoring participants.

www.american.edu/MOVE

Recharge Series

These sessions aim to use the power of dialogue to build community, foster connections with AU colleagues, and share different perspectives. Facilitators from around campus will help create space and open conversations to a variety of topics, which may include themes around play, activism, joy and happiness, and what health means to you.

www.american.edu/recharge

Seated Massage

Relieve tension with a 15- or 30-minute seated massage. Services are provided by a licensed massage therapist with Infinite Massage. Sessions are offered monthly throughout the year. Appointments should be booked in advance online at www.infinitemassage.com. You must register using your American University email address to view the dates and times available at AU.

www.american.edu/hr/AhealthyU/massage.cfm

Steps to AhealthyU Pedometer Challenge

Steps to AhealthyU is a six-week physical activity challenge. Kicking off in late May, teams of four AU faculty and staff members compete to see who can accumulate the most steps as measured by a pedometer. Incentives will be awarded to individuals and teams throughout the challenge.

www.american.edu/pedometer

Walking/Jogging Routes

The university has several mapped routes and walking trails in and around campus. These on-campus walking routes are ideal for walking meetings. Off-campus routes can give a mid-day boost to your energy.

www.american.edu/recfit/facilities/index.cfm

Weigh 2 Win

This 12-week team challenge is much more than the typical weight loss competition! With fitness tools, health resources, support networks, and a jackpot incentive, AhealthyU can help you achieve your weight management goals.

www.american.edu/W2W

WW at Work

Weight Watchers (WW) meetings are held weekly on campus. Sessions last approximately 45 minutes and are led by an experienced WW Workplace Coach. Weekly sessions include a confidential weigh-in to keep you on track and facilitated discussions to help you overcome challenges and celebrate success.

For your convenience, AU offers payroll deduction for the WW meeting fees. For every 10 meetings you attend, AhealthyU will give you a $50 reward (taxes applicable). Members who can’t make the AU meetings can attend in the community and still receive the AhealthyU benefits. To learn more about the WW program, visit www.weightwatchers.com.

www.american.edu/weightwatchers
Disability Coverage

American University offers a rich disability plan for faculty and staff. Of course, no one likes to think about it, but upwards of 40% of Americans will have a short or long term disability at some point in their lives. Without good insurance, a disability could be catastrophic to your family’s finances.

The good news is that American University’s disability plans are generous and designed to replace some or all of your income if you are unable to work due to illness or injury.

Short Term Disability

Should you need to go out on short term disability (STD), you will continue to receive 100% of pay and benefits for as long as you are unable to work, up to six months. For staff, there is a fourteen calendar day waiting period, during which you may substitute sick or annual leave. Staff are required to exhaust sick leave during their disability period. As faculty do not accrue leave, they do not have a waiting period.

AU automatically enrolls you in short term disability coverage at no cost to you. Coverage begins on your first day of full-time employment if you are a full-time faculty member, or after six months of employment if you are a full-time staff member. The maximum short term disability benefit payment period is six months, after which you may be eligible for long term disability (LTD) coverage.

For questions about short term disability or family and medical leave coverage, contact Human Resources at x2591.

Short Term Disability Benefits

<table>
<thead>
<tr>
<th>% OF BASE SALARY</th>
<th>WAITING PERIOD</th>
<th>MAXIMUM BENEFIT PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty Members</td>
<td>100%</td>
<td>0 days</td>
</tr>
<tr>
<td>Staff Members</td>
<td>100%</td>
<td>14 days</td>
</tr>
</tbody>
</table>

Benefits continue until the earliest of:
- The date you are no longer disabled
- The date you reach the maximum benefit period

Long Term Disability

You are automatically enrolled in the university’s long term disability (LTD) plan on the first day of the month after you complete one year of full-time service with the university. The cost of long term disability is based on your salary and is shared evenly by you and the university.

See the Faculty/Staff Benefits Manual for details if you go on short term disability before your eligibility for long term disability coverage begins. Long term disability coverage replaces a portion of your monthly salary if you are unable to work due to sickness or injury after a waiting period (designed to follow after you have used your 180 days of short term disability benefits).

Long Term Disability Benefits

<table>
<thead>
<tr>
<th>% OF BASIC MONTHLY EARNINGS</th>
<th>MAXIMUM BENEFIT PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff and Faculty Members</td>
<td>60%*</td>
</tr>
</tbody>
</table>

*LTD benefits are calculated using your current base annual salary prior to the date your disability begins. Only 50% of any benefit paid to you under the plan is taxable income to you as the premiums are shared by you and the university. Benefits are coordinated with disability benefits under other plans, such as Social Security and state disability programs.

As with all benefits, you should refer to the appropriate sections of the Faculty/Staff Benefits Manual or the official plan documents for more extensive information concerning your benefits plans. In the event of any conflict between this benefits guide or the appropriate descriptive sections of the Faculty/Staff Benefits Manual and the official plan documents, the plan documents will govern.

Your Retirement Contributions Continue on Long Term Disability (up to 15%)

If you participate in the retirement plan and are approved for long term disability, your contributions will continue at no additional expense to you for up to 15% of your pre-disability earnings. (Note: You must be participating in the retirement plan prior to receiving LTD payments to receive this benefit.) The insurance company will make the contributions direct to your TIAA and/or Fidelity accounts.

Can I drop long term disability if I do not want it?
No. Participation is required.
Education Benefits

American University provides eligible faculty and staff members with valuable education benefits, including:
- Tuition remission for eligible courses taken by an employee or an employee’s spouse or same-sex domestic partner at American University or the Wesley Theological Seminary;
- Tuition remission for eligible dependent children who attend American University or the Wesley Theological Seminary; and
- Other education benefits for eligible dependent children.

Tuition Remission

After four months of active full-time employment, you or your spouse/same-sex domestic partner* are eligible for:
- Tuition remission for eligible courses at American University or the Wesley Theological Seminary.

*Opposite-sex domestic partners are not eligible for education benefits.

The maximum benefit available to you or your legal spouse/same-sex domestic partner is 8 credits per semester. The total credits for courses may not exceed 20 credits per academic year per eligible person.

To apply for tuition remission for you or your legal spouse/same-sex domestic partner, complete the tuition remission online application each semester on the myAU portal > Work@AU > Tuition Remission Application. Please note that the tuition remission process is not automatically triggered by your registration; you must complete the application form each semester to receive the benefit.

Graduate courses are 100% taxable and taxation on remitted tuition can significantly reduce your net (take-home) pay. Certain courses are not covered; please review the partial list of covered courses on the myAU portal > Work@AU > Tuition Remission Application. During the summer semester, co-ops, independent studies, individually-arranged classes, and internships are not eligible for coverage. The education benefits program does not cover application fees, course fees, comprehensive examination fees, matriculation fees, or other charges which exceed the standard tuition rate as defined in the course catalogue of tuition and fees. There is a non-refundable $50 administrative fee each semester you apply for tuition remission benefits.

If you have questions about education benefits, contact the Human Resources Benefits Team at x3400.

<table>
<thead>
<tr>
<th>TUITON REMISSION KEY DEADLINES</th>
<th>SPRING 2019</th>
<th>SUMMER 2019</th>
<th>FALL 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hire date for tuition remission</td>
<td>9/18/2018</td>
<td>1/17/2019</td>
<td>5/01/2019</td>
</tr>
<tr>
<td>Classes begin</td>
<td>1/14/2019</td>
<td>5/13/2019</td>
<td>8/26/2019</td>
</tr>
<tr>
<td>Tuition remission application deadline</td>
<td>1/18/2019</td>
<td>5/17/2019</td>
<td>8/30/2019</td>
</tr>
<tr>
<td>Last day to drop a class/make changes for 100% refund and no tuition remission</td>
<td>1/28/2019</td>
<td>Varies*</td>
<td>9/09/2019</td>
</tr>
<tr>
<td>Full tuition remission coverage date (last day of class)</td>
<td>4/29/2019</td>
<td>Varies*</td>
<td>12/06/2019</td>
</tr>
<tr>
<td>Tuition remission taxable amount added to pay</td>
<td>Feb/Mar/Apr paychecks</td>
<td>Jun/Jul/Aug paychecks</td>
<td>Oct/Nov/Dec paychecks</td>
</tr>
</tbody>
</table>

*Please visit the Schedule of Classes website to view the most current key dates for class and tuition remission purposes. www.american.edu/provost/registrar/schedule/index.cfm

Taxation on remitted tuition can significantly reduce your net (take-home) pay. We recommend that you use the Symmetry® calculator on the myAU portal > Work@AU > Tuition Remission Application.

If I am enrolled at American University and I add or drop courses, does my tuition benefit adjust automatically?

No. You must contact the Human Resources Benefits Team at x3400 and Student Accounts to alert us that you have changed the number of courses in which you are enrolled.
Education Benefits

Education Benefits for Dependent Children

After two years of active full-time employment, your eligible dependent child(ren) may receive:

- **AU Tuition Scholarship:** American University or Wesley Theological Seminary undergraduate scholarships for up to four academic years, including two additional courses in summers between academic years.

- **Tuition Exchange, Inc. Scholarship:** Undergraduate tuition scholarships at over 600+ colleges and universities through the competitive scholarship Tuition Exchange network for up to four academic years.

- **Cash Grants for Tuition Expenses:** $725 per semester (fall and spring only) with a combined maximum of $1,450 per academic year for full-time faculty and staff hired before July 1, 1995.

To apply for the AU Tuition Scholarship or cash grants, complete the Dependent Child Education Benefits online application on the myAU portal > Work@AU > Dependent Child Educational Benefits Application. To apply for the Tuition Exchange Scholarship for the first time, visit www.tuitionexchange.org.

Dependent children are eligible for up to 8 semesters of education benefits. If they are enrolled at AU, they are also eligible for two courses during the summer months between academic years. The maximum benefit for tuition scholarships is up to four years, with no more than two of those years being for graduate education.

Graduate courses are 100% taxable and certain courses are not covered. Please review the partial list on the myAU portal > Work@AU > Tuition Remission Application. During the summer semester, co-ops, independent studies, individually-arranged classes, and internships are not eligible for coverage. Be sure to refer to the Faculty/Staff Benefits Manual for detailed information about covered courses, taxes, critical deadlines, and more.

Commonly Asked Questions

**How do I apply for education benefits?**

For tuition remission for you or your legal spouse/same-sex domestic partner, complete the tuition remission online application for each semester on the myAU portal > Work@AU > Tuition Remission Application.

To apply for the AU Tuition Scholarship and/or cash grants, complete the Dependent Child Education Benefits online application on the myAU portal. First time applicants for the Tuition Exchange Scholarship need to complete the online application at www.tuitionexchange.org.

**Are fees covered by tuition remission?**

No. The education benefits program does not cover application fees, course fees, comprehensive examination fees, matriculation fees, or other charges which exceed the standard tuition rate. There is a non-refundable $50 administrative fee each semester you apply for tuition remission benefits.

**Are courses at institutions, other than American University or Wesley Seminary covered for employee and/or spouse/same-sex domestic partners?**

Generally speaking, no. There is a provision made for employees in a doctoral program who need to take a required course that is not available at AU. In that limited circumstance only, the university may cover the cost of the course. Please see the Faculty/Staff Benefits Manual for more specifics.

**Are some courses ineligible for employee/spouse/same-sex domestic partner tuition remission at AU?**

Yes. Please review the partial list on the online tuition remission application form. During the summer semester, co-ops, independent studies, individually-arranged classes, and internships are not eligible for coverage.

**Are study abroad programs covered under education benefits for dependent children?**

In some cases, yes. Generally, your child must be enrolled full-time at AU and participating in an AU study abroad program to continue to receive the AU scholarship while abroad.

**Can I take a leave of absence and receive education benefits for myself or my child?**

In some cases, you may be eligible to be out on approved leave without pay and continue to receive education benefits.

If I have received, or am receiving, education benefits, and I resign from my position at the university, will I be required to reimburse the university?

If you leave the university during a semester during which you or your dependents are using education benefits, you will be responsible for a pro-rated portion of the tuition.
Work-Life

American University is pleased to provide work-life benefit programs and policies that support you and your family. In addition to our core benefits, wellness activities, and professional development, we offer several resources to achieve a gratifying and productive balance of your personal and professional time. We have highlighted just a few of our programs and services in this guide but encourage you to explore our full offerings online at www.american.edu/hr.

Flexible Work Arrangements for Staff

American University supports flex work arrangements to foster a desirable and productive work environment that is responsive to the challenges of finding new and better ways to service our students and other customers while balancing the demands of home life.

While not all positions are amenable to flex work arrangements, consideration of flexible work schedules will be reviewed on a case-by-case basis considering the department’s needs and the employee’s ability to maintain a high level of service. The university’s expectation is that the quantity, quality, and productivity of the employee’s work will be enhanced because of the flexible work arrangement. All flex work arrangements must be approved in advance by an authorized official.

If you need further assistance with this request, please contact Human Resources at x2591.

Did you know that . . . ?

Flex work arrangements are work hours or a work week that vary from the standard schedule and include:

- Flex time
- Compressed work week
- Telework
- Reduced work schedules

Nursing Mothers

The university provides lactation rooms to support nursing mothers returning to work, school, or campus. Any nursing mother who is an American University community member (faculty, staff, student, or contract employee) or their spouse, opposite- or same-sex partner can use any of the lactation rooms.

Each lactation room offers a clean, secure, and private space for women who need to express breast milk during their time on campus. All rooms are equipped with comfortable seating, table, and ample electrical outlets near the chair. Faculty or staff with questions about lactation rooms or workplace accommodations should contact the Employee Relations Team in Human Resources at x2607 or employeerelations@american.edu.

www.american.edu/hr/WorkLife/Lactation.cfm

Child Development Center

American University’s Child Development Center (CDC) provides on-campus, high-quality education and care for children 2-1/2 to 6 years of age. Our mission is to offer a developmentally appropriate educational program for pre-school children, support families within the campus community, and promote the overall educational mission of the university.

The CDC provides family caregivers within the AU community an opportunity to pursue a university education or career while receiving high quality child care for their families.

Faculty & Staff Assistance Program (FSAP)

The Faculty & Staff Assistance Program (FSAP) is confidential and makes professional personal counseling services available to faculty and staff members and their immediate families. The cost of FSAP services is paid entirely by the university.*

FSAP provides assessment, short-term counseling, referral to community services, follow-up contact, and other services. These services provide assistance in coping with:

- Physical or emotional problems;
- Family and workplace stress and related issues;
- Alcohol and other substance abuse;
- Child care and elder care;
- Other issues or problems that may affect emotional or physical health and well-being;
- Assistance with emergency loans with repayment through scheduled paycheck deductions. The emergency loan is intended to assist university full-time employees who have urgent financial needs.

FSAP counseling sessions are strictly confidential. FSAP information may only be released by written consent, and is not placed in personnel files.

*You will be responsible for any costs that may result from referral to an outside community resource. You should check the terms of your medical care and flexible spending account programs to determine whether these plans will cover your costs.
Dependent Care and Family Services & Resources

Bright Horizons Back-Up Care™

Emergency Back-up Dependent Care

Bright Horizons® provides you with emergency back-up dependent care when you experience a break down in your regular care. The Care Advantage Program consists of a nationwide network of child care centers and in-home care agencies that are available to you at a moment’s notice.

AU full-time faculty and staff are eligible for:

- 15 days of subsidized, emergency back-up care per calendar year;
- Copayment of $15/child/day or $25/family/day for center-based child care;
- Copayment of $8/hour for in-home care.

Dependent care includes children, adults, and elderly loved ones. For example, emergency back-up care can be used when:

- Your child’s school closes due to inclement weather, but you are scheduled to work;
- Your child is mildly ill and needs to stay home from school or day care;
- You are transitioning care arrangements for your elderly parents or in-laws.

Additional Family Support

Bright Horizons provides referral services and discounts for non-emergency child care, elder care, pet sitting, tutoring, and housekeeping services.

- **Nannies, Elder Care, Pet Care, and More**
  American University faculty and staff have subsidized access to a database of nannies and sitters for full-time or part-time care, elder caregivers, pet sitters, and housekeepers.

- **Senior Care Planning Resources**
  The Bright Horizons web-based research platform assesses your senior care needs. Or you can use their personal assessment partners at a discounted rate.

Bright Horizons

Customer Service: (877) BH-CARES
          (877) 242-2737

www.careadvantage.com/AU
Initial User Name: AU
Initial Password: Backup1

- **Test Prep and Tutoring Services**
  Referral service for private and small group tutoring for SATs/ACTs, standardized tests, common core subjects, and general help for students.

- **Deals and Discounts at Child Care Centers**
  Preferred enrollment at Bright Horizons centers and tuition discounts nationwide at participating child care centers.

Register for free to make a reservation for emergency back-up care or to access any of the dependent care/family services and resources. Advanced registration is highly recommended for the back-up care service. To register, visit:

www.careadvantage.com/AU
Initial User Name: AU
Initial Password: Backup1

Or call (877) BH-CARES. Bright Horizons’ care consultants are available 24/7 and they can walk you through registration or help you make a reservation.
Commuter Benefits

Reduce your commuting expenses for work-related transit and parking expenses by using pre-tax money for these items.

- You may allocate up to $260 per month, pre-tax, for Metro, VRE, MARC train fares, vanpools, and ride sharing services such as Lyft Line and uberPOOL. You may allocate up to $260 per month, pre-tax, for parking at WMATA® Park and Ride locations.*
- Please keep in mind that you must place your commuter order by the 10th of each month for the following month. Orders received by the 10th of the month are processed and mailed no later than the 23rd of that month.
- You can set your order to recur monthly and it will repeat automatically each month or you can designate, in advance, which months you wish to receive your commuter benefits.

SmarTrip® Cards

SmarTrip cards are permanent, rechargeable cards that are used to pay Metrobus and Metrorail fares. If you don’t already have one, you will initially need to purchase a card from WMATA or a participating retailer and register your new card with WMATA.

- SmarTrip card users must make separate elections for transit expenses and for parking expenses at WMATA Park and Ride locations.*

*The use of ConnectYourCare commuter benefits for parking applies to WMATA® Park and Ride locations only. For parking at AU parking facilities, please contact Public Safety. At the time of printing of this benefits guide, the IRS had not yet released the 2019 benefits limits.

Commuter Check Prepaid Mastercard®

This reloadable prepaid card can only be used to purchase transit fares from qualified transit authorities where Debit Mastercard is accepted†. We recommend participants load an amount that’s appropriate for their normal monthly commute.

IMPORTANT: Do not order the Commuter Check Prepaid Mastercard if you intend on using it for:

- WMATA Metrobus or Metrorail
- MTA (Baltimore)

Accepted by:
- MARC
- VRE
- WMATA Park and Ride locations
- Uber
- Lyft

†The Commuter Check Prepaid Mastercard may only be used for qualified commuter benefit purchases in accordance with IRS Tax Code 132(f). No cash or ATM access. This card may not be used everywhere Debit Mastercard is accepted.

Bicycle Commuter Benefit

In support of our sustainability initiative, American University offers a bicycle benefit that is fully paid by the university. Faculty and staff can receive a $20 voucher‡ for each month that they commute regularly by bicycle for a substantial portion of their travel between home and work. The voucher is intended to pay for the purchase, storage, repair, and maintenance of a bicycle. Participants are eligible for only one commuter benefit per month – either the SmarTrip card, the Commuter Check Prepaid card, or the bicycle commuter benefit. To receive the bicycle commuter benefit:

1. Plan for and monitor your use of the benefit.
2. Print out a Bicycle Commuting Benefit affidavit available online on the Benefits site at www.american.edu/hr. Sign and return the attached affidavit to AhealthyU by the 10th of the month preceding your commuting benefit start date.
3. Log onto www.connectyourcare.com to enter your election by the 10th of each month for the following month or designate in advance the months that you’ll be biking to work.
4. Update your elections throughout the year to ensure that your anticipated bicycle commuting accurately reflects your actual usage of the bicycle commuting benefit.

‡$20 voucher is taxable.
Vision Coverage

VisionAccess Program

The VisionAccess Program discount uses the Vision Service Plan (VSP) provider network and promotes preventive care through regular eye exams and early corrective treatment.

Cost

There is no charge for the vision discount plan.

<table>
<thead>
<tr>
<th>ROUTINE EXAM</th>
<th>EYEGLASSES, FRAMES AND LENSES</th>
<th>CONTACT LENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareFirst</td>
<td>$10 copayment at program-designated Vision Care Centers (referral not required). $25 copayment at network provider offices. Limited to one per calendar year.</td>
<td>Discounts available at participating vision centers.</td>
</tr>
<tr>
<td>Kaiser</td>
<td>$20 copayment for a routine exam by an optometrist. $40 copayment for a routine exam by an ophthalmologist.</td>
<td>Discount when purchased through Kaiser.</td>
</tr>
<tr>
<td>VisionAccess Program (Sample discounts)</td>
<td>20% off eyeglass exam and 15% off contact lens exam.</td>
<td>20% off lenses and 20% off frames.</td>
</tr>
</tbody>
</table>

Did you know that a vision exam can help keep tabs on your overall health? An annual eye exam is a simple, low-stress way to keep tabs on your eye and overall health.

The discounts in the MetLife VisionAccess program are automatically available to you. Simply give the participating vision provider/center the program code: MET2020 and they will automatically charge you the discounted rate.

MetLife
Customer Service: (866) 363-8669
www.metlife.com/mybenefits

Determining Your Needs

If you are already enrolled, or enrolling, in an AU-sponsored health plan, you receive vision benefits through that plan. Depending on the extent of your vision needs, you may find that the benefits offered by your AU-sponsored medical plan are sufficient. If you are not enrolled in an AU-sponsored health plan or wish to go to a different vision provider, you may wish to use this vision discount plan. Use this chart to assist you in determining whether the VisionAccess Program is right for you.
Pet Insurance

Nationwide® Pet Insurance Plan

Nationwide offers pet insurance coverage through MetLife and ensures that you can provide your pet with the care it needs.

Pet coverage helps with everything from minor problems such as ear infections and allergies, to serious conditions like cancer and heart diseases.

MetLife offers a choice of plans:

- For dogs and cats starting at 6 weeks of age
- For birds, ferrets, reptiles and other exotic pets. Birds must be at least 3 months old and in the owner's possession for 60 days
- Visit any licensed veterinarian worldwide
- Receive a special 5% AU discount
- Policies can be paid by payroll deduction

Cost

Premium rates vary based on the age of the pet, species, size, plan type, deductible and state of residence.

*Rate discount applies to the base medical wellness plans only.

<table>
<thead>
<tr>
<th>DOGS AND CATS</th>
<th>WELLNESS PLUS®</th>
<th>MAJOR MEDICAL®</th>
<th>MAJOR MEDICAL + WELLNESS PLUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Any Vet</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Accidents</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Including poisonings, cuts and broken bones</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Illnesses</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Including ear infections, rashes, vomiting and diarrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious/Chronic Illnesses*</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Including cancer, diabetes and allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hereditary Conditions†</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Procedures/Services</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Including surgeries, Rx meds, testing and hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellness Services</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Including exams, vaccinations and flea/heartworm preventives</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*New illnesses only. Does not include conditions pre-existing to enrollment.
†Limited hereditary condition coverage after the first year of enrollment.
‡Wellness plans are not available in all states.

MetLife
Customer Service: (800) USA-PETS
www.metlife.com/mybenefits
Group Auto and Home Insurance

MetLife Auto and Home is a portable, voluntary group auto and home benefit program that provides you with access to insurance coverage for your personal insurance needs. Policies available include:

- Auto
- Home
- Landlord’s rental dwelling
- Condo
- Mobile home
- Renters
- Recreational vehicle
- Boat
- Personal excess liability (“umbrella policies”)

Policies can be paid by payroll deduction or debit from your checking account. This program also gives you access to special group discounts.

Enrollment

As your insurance policies renew at different times during the year, you may apply for group auto and home insurance at any time. Call MetLife to get a free, no obligation premium quote. If you choose to switch, MetLife can help you apply for insurance while you’re on the phone. Please have your current insurance policy with you when you call. Some restrictions may apply.

Upon leaving the university, MetLife will set up direct billing so that you can continue your coverage.

I am going on unpaid leave. Do I need to do anything?

When you are on unpaid leave and your group auto and home insurance is paid through payroll deduction, you will need to pay your premiums out-of-pocket through the benefits office to continue coverage.

MetLife Group Auto & Home
AU Designated Agent: Geomara Polanco
(703) 216-9675
www.metlife.com/mybenefits
Medical Plan Comparison

You should refer to the appropriate sections of the Faculty/Staff Benefits Manual or the official plan documents for more extensive information concerning your benefits plans. In the event of any conflict between this benefits guide or the appropriate descriptive sections of the Faculty/Staff Benefits Manual and the official plan documents, the plan documents will govern.

Medical Benefits Summary Chart

<table>
<thead>
<tr>
<th></th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Choice of Physician</td>
<td>May use any provider in Blue Choice, BluePreferred PPO, or BlueCard PPO. No referrals required.</td>
<td>Choose any physician. No network limitations. No referrals required.</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$400 Individual $800 Individual + one $800 Family</td>
<td>$1,000 Individual $2,000 Individual + one $2,000 Family</td>
</tr>
<tr>
<td>Note: The in-network deductible applies to non-preventive care services. Preventive care such as annual physical and mammograms are not subject to the deductible, however copayments still apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$20 Primary Care $40 Specialty Care No copayment for preventive care office visits. No copayment for women's preventive health services.</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90% paid by health plan* 10% paid by participant</td>
<td>65% paid by health plan* 35% paid by participant</td>
</tr>
</tbody>
</table>

*The amount that BCBS will pay for a given covered service is determined by the Plan Allowance for that service. The Plan Allowance for covered services is determined by the contracted rate or fee schedule that participating providers have agreed to accept for that service or the rate or fee that is established by law. Throughout this document this definition will be referred to as “plan allowance.”
## Medical Plan Comparison

### Medical Benefits Summary Chart (continued)

<table>
<thead>
<tr>
<th></th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAIser PERMANente</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket Expense</td>
<td>$2,750 Individual</td>
<td>$4,000 Individual</td>
</tr>
<tr>
<td></td>
<td>$5,500 Individual + one</td>
<td>$8,000 Individual + one</td>
</tr>
<tr>
<td></td>
<td>$5,500 Family</td>
<td>$8,000 Family</td>
</tr>
<tr>
<td>Note: The BlueChoice plan does not cover any portion of your medical bills until you first meet your annual deductible; copayments still apply and do not count toward the deductible. After the deductible is met for the year, you pay the copayment for certain covered services. Most covered services are reimbursed by BCBS at 90% of plan allowance and you pay 10%. If you reach the maximum out-of-pocket expense for the year, BCBS pays 100% of plan allowance(s) for covered expenses for the remainder of that year. Example: With individual coverage you first pay the $400 annual deductible and office visit copayment for non-preventive care. Then, copayments or other cost-sharing applies. If your out-of-pocket expense totals $2,750, BCBS pays 100% of plan allowance(s) for the remainder of the year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Claim Forms</td>
<td>No claim forms to file.</td>
<td>May need to file your own claims. If your physician participates with BCBS through another plan, they are by contract required to submit your claims on your behalf as BCBS will reimburse them directly.</td>
</tr>
<tr>
<td>Pre-Certification</td>
<td>Hospital certifications arranged by physicians.</td>
<td>Responsible for arranging own hospital certifications. Financial penalty if pre-certification is not arranged.</td>
</tr>
</tbody>
</table>
### Medical Plan Comparison

#### Prescription Drug Coverage

Under Kaiser, there is no copayment for any contraceptives or contraceptive devices. Under Express Scripts, there is no coinsurance for any generic contraceptives, brand contraceptives with no generic equivalent, or devices.

<table>
<thead>
<tr>
<th></th>
<th>EXPRESS SCRIPTS (CareFirst Participants)</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RETAIL PHARMACY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>(1 month supply)</td>
<td></td>
<td>$20</td>
</tr>
<tr>
<td>Brand Name</td>
<td>30% coinsurance to $30 max*</td>
<td>$20</td>
</tr>
<tr>
<td>Formulary Drugs</td>
<td></td>
<td>$40</td>
</tr>
<tr>
<td>(1 month supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand Name</td>
<td>50% coinsurance to $50 max*</td>
<td>$35</td>
</tr>
<tr>
<td>Non-Formulary Drugs</td>
<td></td>
<td>$55</td>
</tr>
<tr>
<td>(1 month supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excluded Drugs†</td>
<td>100% participant responsibility</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>HOME DELIVERY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$25</td>
<td>$20</td>
</tr>
<tr>
<td>(3 month supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand Name</td>
<td>30% coinsurance to $75 max</td>
<td>$40</td>
</tr>
<tr>
<td>Formulary Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3 month supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand Name</td>
<td>50% coinsurance to $125 max</td>
<td>$70</td>
</tr>
<tr>
<td>Non-Formulary Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3 month supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excluded Drugs†</td>
<td>100% participant responsibility</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>OUT-OF-POCKET</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual†</td>
<td>$3,850</td>
<td>Included with medical</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual + 1/Family†</td>
<td>$7,700</td>
<td>Included with medical</td>
</tr>
</tbody>
</table>

*After the first three retail prescription fills for maintenance drugs, CareFirst participants pay an additional $10 for each retail fill. Use CVS Smart90 program or switch to Home Delivery to avoid the surcharge.

†Excluded drugs do not apply towards out-of-pocket maximums.

### Durable Medical Equipment

<table>
<thead>
<tr>
<th></th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td>OUT-OF-NETWORK</td>
<td>HMO</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>90% of plan allowance. Subject to deductible.</td>
<td>65% of plan allowance – after you’ve met the annual deductible.</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Subject to annual deductible, then 90% of allowed amount per 36-month period. Amount above the allowed amount is billed to the member.</td>
<td>Subject to annual deductible, then 65% of allowed benefit per 36-month period. Amount above the allowed amount is billed to the member.</td>
</tr>
</tbody>
</table>
# Medical Plan Comparison

## Outpatient Physician Visits

<table>
<thead>
<tr>
<th>Medical Services and Physician Office Visits</th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>HMO</td>
</tr>
<tr>
<td>Primary Care Provider: 100% coverage - after $20 per visit copayment. Specialist: 100% coverage - after $40 per visit copayment. Subject to deductible for non-preventive care services.</td>
<td>65% of plan allowance - after you've met the annual deductible.</td>
<td>Primary Care Physician: 100% coverage after $20 copayment. Specialist: 100% coverage after $40 visit copayment. No copayment for primary care physician office visits for children under 5. (Note: specialist copayment applies for children under 5.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well Baby Care</th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>HMO</td>
</tr>
<tr>
<td>Primary Care Provider: 100% coverage.</td>
<td>65% of plan allowance - not subject to deductible. Unlimited visits up to age 18.</td>
<td>100% coverage up for preventive services for children.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routine Physicals</th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>HMO</td>
</tr>
<tr>
<td>Primary Care Provider: 100% coverage.</td>
<td>Not covered.</td>
<td>100% coverage for preventive services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Physician Visits</th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>HMO</td>
</tr>
<tr>
<td>Primary Care Provider: 100% coverage - after $20 per visit copayment. Specialist: 100% coverage - after $40 per visit copayment. Subject to deductible for non-preventive services.</td>
<td>65% of plan allowance - after you've met the annual deductible.</td>
<td>100% coverage - when medically necessary. Subject to evaluation and authorization by plan.</td>
</tr>
</tbody>
</table>

## Hospital Admissions

<table>
<thead>
<tr>
<th>Medical, Surgical, Obstetrical</th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>HMO</td>
</tr>
<tr>
<td>90% coverage - after $250 copayment - when admitted by a BCBS physician to an approved hospital only at approved locations. Subject to deductible.</td>
<td>65% of plan allowance - after you've met the annual deductible (pre-certification is required).</td>
<td>100% coverage - after $250 copayment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rehabilitative Admission (Not related to alcohol and drug abuse treatment and rehabilitation)</th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>HMO</td>
</tr>
<tr>
<td>After $250 copayment covered for up to 30 days per confinement in an acute care hospital when hospitalization is medically necessary and authorized by BCBS. Subject to deductible.</td>
<td>Not Covered.</td>
<td>100% coverage - after $250 copayment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preadmission Testing</th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>HMO</td>
</tr>
<tr>
<td>90% coverage - after annual deductible is met – at approved locations. If testing requires a hospital stay, $250 copayment. Subject to deductible.</td>
<td>65% of plan allowance - after you've met the annual deductible for diagnostic testing, x-rays and lab work when rendered in the outpatient department of a hospital.</td>
<td>100% coverage. If testing requires a hospital stay, $250 copayment applies.</td>
</tr>
</tbody>
</table>
## Medical Plan Comparison

### Emergency Care

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CareFirst BlueChoice Advantage</th>
<th>Kaiser Permanente</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Services (in and out of area)</strong> (Urgent care centers are available at Kaiser facilities for urgent and non-life threatening emergencies.)</td>
<td><strong>IN-NETWORK</strong>  90% coverage - after $100 copayment per visit for bona fide emergency. $100 is waived if admitted as inpatient to the hospital. Subject to deductible.</td>
<td><strong>OUT-OF-NETWORK</strong>  90% of plan allowance - after $100 copayment per visit for bona fide emergency. $100 is waived if admitted as inpatient to the hospital. Subject to deductible.</td>
</tr>
<tr>
<td></td>
<td><strong>HMO</strong>  100% coverage - after $75 copayment when life-threatening situation or when authorized by plan. If admitted, $75 copayment is waived but $250 inpatient copayment will apply.</td>
<td><strong>AMBULANCE SERVICES</strong>  90% coverage of ground ambulance to hospital for authorized emergency. Subject to deductible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>HMO</strong>  100% coverage after $50 copayment - when life-threatening situation or when authorized by plan.</td>
</tr>
</tbody>
</table>

### Surgery Care

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CareFirst BlueChoice Advantage</th>
<th>Kaiser Permanente</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td><strong>IN-NETWORK</strong>  Primary Care Provider: 100% coverage - after $20 per visit copayment. Specialist: 100% coverage after $40 copayment. Facility: 90% coverage subject to deductible. Subject to deductible for non-preventive care services.</td>
<td><strong>OUT-OF-NETWORK</strong>  65% of plan allowance - after you've met the annual deductible (pre-certification is required).</td>
</tr>
<tr>
<td></td>
<td><strong>HMO</strong>  100% coverage after $50 copayment.</td>
<td><strong>AMBULANCE SERVICES</strong>  100% coverage after $50 copayment.</td>
</tr>
<tr>
<td><strong>Inpatient Surgery</strong></td>
<td><strong>IN-NETWORK</strong>  90% coverage for an approved admission after $250 copayment. Subject to deductible.</td>
<td><strong>OUT-OF-NETWORK</strong>  65% of plan allowance - after you've met the annual deductible.</td>
</tr>
<tr>
<td></td>
<td><strong>HMO</strong>  100% coverage after $250 copayment.</td>
<td><strong>AMBULANCE SERVICES</strong>  100% coverage after $50 copayment.</td>
</tr>
<tr>
<td><strong>Second or Multiple Surgical Opinion Consultation</strong></td>
<td><strong>IN-NETWORK</strong>  Specialist: 100% coverage after $40 per visit copayment. Subject to deductible. Paid in full if requested by CareFirst.</td>
<td><strong>OUT-OF-NETWORK</strong>  65% of plan allowance - after you've met the annual deductible.</td>
</tr>
<tr>
<td></td>
<td><strong>HMO</strong>  100% coverage after $40 per visit copayment.</td>
<td><strong>AMBULANCE SERVICES</strong>  100% coverage after $50 copayment.</td>
</tr>
<tr>
<td><strong>Anesthesia Services</strong></td>
<td><strong>IN-NETWORK</strong>  Inpatient: 90% coverage. Subject to deductible.</td>
<td><strong>OUT-OF-NETWORK</strong>  65% of plan allowance - after you've met the annual deductible.</td>
</tr>
<tr>
<td></td>
<td><strong>HMO</strong>  100% coverage.</td>
<td><strong>AMBULANCE SERVICES</strong>  100% coverage.</td>
</tr>
<tr>
<td><strong>Organ Transplant</strong></td>
<td><strong>IN-NETWORK</strong>  90% coverage for limited services. Subject to deductible.</td>
<td>65% of plan allowance for limited services - after you've met the annual deductible.</td>
</tr>
<tr>
<td></td>
<td><strong>HMO</strong>  100% coverage for limited services when authorized by plan.</td>
<td><strong>AMBULANCE SERVICES</strong>  100% coverage after $50 copayment.</td>
</tr>
</tbody>
</table>
### Medical Plan Comparison

#### Inpatient Physician Visits

<table>
<thead>
<tr>
<th></th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAIser PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Medical/Surgical Physician Services</td>
<td>90% coverage for an approved admission. Subject to deductible.</td>
<td>65% of plan allowance – after you’ve met the annual deductible.</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>90% coverage for an approved admission. Subject to deductible.</td>
<td>65% of plan allowance – after you’ve met the annual deductible.</td>
</tr>
<tr>
<td>Inpatient Consultation</td>
<td>90% coverage for an approved admission. Subject to deductible.</td>
<td>65% of plan allowance – after you’ve met the annual deductible.</td>
</tr>
</tbody>
</table>

#### Nursing Care

<table>
<thead>
<tr>
<th></th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Inpatient Private Duty Nurse</td>
<td>90% coverage after annual deductible is met when authorized by plan for an approved admission due to medical necessity.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Outpatient Private Duty Nurse</td>
<td>Not covered.</td>
<td>65% of plan allowance – after you’ve met the annual deductible. Limited to a maximum of two hours a day (1 visit) up to 50 visits per calendar year.</td>
</tr>
</tbody>
</table>
# Medical Plan Comparison

## Maternity Care

<table>
<thead>
<tr>
<th></th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
<td>HMO</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>90% coverage - after $250</td>
<td>65% of plan allowance - after you’ve met the annual deductible.</td>
</tr>
<tr>
<td></td>
<td>copayment at approved locations.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subject to deductible.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Hospital</strong></td>
<td>90% coverage at approved locations.</td>
<td>65% of plan allowance - after you’ve met the annual deductible.</td>
</tr>
<tr>
<td></td>
<td>Subject to deductible.</td>
<td></td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>100% coverage after $40 per visit copayment. (Up to $400 copayment per pregnancy.) Subject to deductible.</td>
<td>65% of plan allowance - after you’ve met the annual deductible.</td>
</tr>
<tr>
<td><strong>Nurse Midwife</strong></td>
<td>100% coverage after $40 per visit copayment. (Up to $400 copayment per pregnancy. Nurse Midwife must be associated with an approved center.) Subject to deductible.</td>
<td>65% of plan allowance - after you’ve met the annual deductible.</td>
</tr>
<tr>
<td><strong>Birthing Center</strong></td>
<td>100% coverage after $40 per visit copayment. Subject to deductible. (Up to $400 copayment per pregnancy, at approved locations.)</td>
<td>65% of plan allowance - after you’ve met the annual deductible.</td>
</tr>
</tbody>
</table>

## Therapeutic Services

<table>
<thead>
<tr>
<th></th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
<td>HMO</td>
</tr>
<tr>
<td><strong>Radiation/Chemotherapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis (Physician)</td>
<td>100% coverage - after $40 per visit copayment or $20 copayment for primary care provider. Subject to deductible.</td>
<td>65% of plan allowance of covered services - after you’ve met the annual deductible.</td>
</tr>
<tr>
<td>Physical Therapy Physician-</td>
<td>100% coverage after $40 per visit copayment for short term care up to 40 visits. Subject to deductible. (Short term care means significant improvement is expected within 90 days.)</td>
<td>65% of plan allowance - after you’ve met the annual deductible. 40 visit limit (combined with in-network).</td>
</tr>
<tr>
<td>Billed or Physical Therapist Billed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy (Outpatient Physician)</td>
<td>100% coverage - after $40 per visit copayment. Subject to deductible.</td>
<td>65% of plan allowance - after you’ve met the annual deductible.</td>
</tr>
<tr>
<td>Occupational Therapy (Outpatient Physician)</td>
<td>100% coverage - after $40 per visit copayment. Subject to deductible.</td>
<td>65% of plan allowance - after you’ve met the annual deductible.</td>
</tr>
</tbody>
</table>
## Medical Plan Comparison

### Diagnostic and Screening Services

<table>
<thead>
<tr>
<th></th>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>90% coverage only at approved locations. Subject to deductible.</td>
<td>65% of plan allowance - after you’ve met the annual deductible.</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency CT Scans and MRIs</td>
<td>$40 copayment. Subject to deductible.</td>
<td>65% of plan allowance - after you’ve met the annual deductible.</td>
</tr>
<tr>
<td>Family Planning/Fertility</td>
<td>Primary Care Provider: 100% coverage - after $20 per visit copayment. Subject to annual deductible then 100% of allowed benefit to $100,000 lifetime maximum. Specialist: 100% coverage - after $40 per visit copayment. Subject to annual deductible then 100% of allowed benefit to $100,000 lifetime maximum. Prior authorization is required. Documented 1 year period of trying to become pregnant. Diagnosis and treatment of infertility including medically necessary, non-experimental artificial insemination and In-Vitro Fertilization (IVF).</td>
<td>Testing provided to determine that a diagnosis for infertility exists. The testing is covered at 65% of plan allowance - after you’ve met the annual deductible. No further benefits available if diagnosis is confirmed.</td>
</tr>
<tr>
<td>Preventive Care Mammography</td>
<td>100% coverage.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>65% of plan allowance - after you’ve met the annual deductible. Limited to: Ages 35-39: one preventive mammogram of both breasts in the 5 years. Ages 40-49: one preventive mammogram of both breasts every 2 years. Ages 50 and above: one preventive mammogram of both breasts every year.</td>
<td>100% coverage. No copayment.</td>
</tr>
</tbody>
</table>
Medical Plan Comparison

Transgender Care

<table>
<thead>
<tr>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td>Transgender Care</td>
<td>Covers pre- and post-surgical hormone therapy, surgery if performed by a qualified provider and in conformance with HBIGDA standards. Requires pre-authorization. Surgical, hospital, and laboratory benefits subject to $400,000 lifetime max.</td>
</tr>
</tbody>
</table>

Mental Health Care

<table>
<thead>
<tr>
<th>CAREFIRST BLUECHOICE ADVANTAGE</th>
<th>KAISER PERMANENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td>Outpatient Mental Health Care</td>
<td>100% coverage - after $20 per visit copayment. Subject to deductible. Includes psychotherapy for gender identity disorders.</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>$20 copayment per visit, subject to annual deductible, then 100% of allowed benefit. Coverage for psychological and neuropsychological testing is provided for outpatient services to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse including psychological and neuropsychological testing for psychological diagnostic purposes. Services include evaluation, diagnosis and treatment of acute and non-acute conditions. The benefits for neuropsychological testing are not counted toward any outpatient mental health and substance abuse visit benefit.</td>
</tr>
<tr>
<td>Inpatient Mental Health Care</td>
<td>90% coverage after $250 copayment for short term, acute mental health conditions. Subject to deductible.</td>
</tr>
</tbody>
</table>
Medical Plan Comparison

Non-Hospital Care

<table>
<thead>
<tr>
<th>CareFirst BlueChoice Advantage</th>
<th>Kaiser Permanente</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>90% coverage. No limit. Subject to deductible. Available during last 6 months of life.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90% coverage. Subject to deductible.</td>
</tr>
<tr>
<td>Extended Care Facility (ECF)</td>
<td>90% coverage when authorized by plan. Subject to deductible.</td>
</tr>
</tbody>
</table>

Alcohol and Drug Abuse Treatment

<table>
<thead>
<tr>
<th>CareFirst BlueChoice Advantage</th>
<th>Kaiser Permanente</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td>Outpatient Alcohol/Substance abuse</td>
<td>Physician expenses: 100% coverage - after $20 per visit copayment. Subject to deductible.</td>
</tr>
<tr>
<td>Inpatient Alcohol/Substance Abuse Treatment</td>
<td>Detoxification: 90% coverage after $250 copayment. Subject to deductible. Rehabilitation: 90% coverage after $250 copayment. Subject to deductible. Coverage for up to 30 days. (Note: All detoxification and rehabilitation benefits count against the mental health day/visit maximums.)</td>
</tr>
</tbody>
</table>
## Special Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Carefirst BlueChoice Advantage</th>
<th>Kaiser Permanente HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>HMO</strong></td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td>$40 copayment; subject to in-network deductible; up to 20 visits. Covers acupuncture for pain management and anesthesia. Coverage will be provided when such treatment is rendered by a trained practitioner who is licensed or certified as such by the duly constituted authority in the area in which service is rendered and when acting within the scope of such license or certification; and if the practitioner rendering the acupuncture treatment is not an M.D., such treatment must be under the direct supervision of an M.D.</td>
<td>65% of plan allowance - after you've met the annual deductible; no visit limit. Covers acupuncture for pain management and anesthesia. Coverage will be provided when such treatment is rendered by a trained practitioner who is licensed or certified as such by the duly constituted authority in the area in which service is rendered and when acting within the scope of such license or certification; and if the practitioner rendering the acupuncture treatment is not an M.D., such treatment must be under the direct supervision of an M.D.</td>
</tr>
<tr>
<td><strong>Chiropractic</strong></td>
<td>$40 copayment; subject to in-network deductible; up to 20 visits.</td>
<td>65% of plan allowance - after you've met the annual deductible; no visit limit.</td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td>Discounted dental benefits provided for limited number of services.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Eye Exams (routine)</strong></td>
<td>Participating vision center: 100% coverage - after $10 per visit copayment. Participating ophthalmologist: 100% coverage - after $25 per visit copayment. Limited to one per calendar year.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Eyeglasses and Contact Lenses</strong></td>
<td>Discounts available at participating vision centers. There is an additional cost for contact lens fittings.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Hearing Screening Exams</strong></td>
<td>100% coverage - after $20 per visit copayment. Subject to deductible.</td>
<td>65% of plan allowance - after you've met the annual deductible if exam is required as result of accidental injury.</td>
</tr>
<tr>
<td><strong>Inoculations (including travel inoculations)</strong></td>
<td>Primary Care Provider: $20 copayment per visit. Subject to annual deductible, then 100% of allowed benefit. Specialist: $40 copayment per visit. Subject to annual deductible, then 100% of allowed benefit.</td>
<td>65% of plan allowance - after you've met the annual deductible.</td>
</tr>
</tbody>
</table>
COBRA

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you recently have become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

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 below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you 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 of the following qualifying events happen:

- 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
- Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.
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 60 days after the qualifying event occurs. You must provide this notice with documentation to: American University Human Resources Office, 4400 Massachusetts Avenue, Washington, DC 20016-8054. Please contact Human Resources at (202) 885-2591 for additional information.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide this notice with documentation to: American University Human Resources Office, 4400 Massachusetts Avenue, Washington, DC 20016-8054. Please contact Human Resources at (202) 885-2591 for additional information.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

American University Human Resources Office
4400 Massachusetts Ave, NW
Washington, DC 20016-8054
(202) 885-2591

ACA Health Care Exchanges

There are other health and dental coverage options available for you and your family. You may purchase coverage through the health insurance marketplace even if you are also eligible for coverage under COBRA. The marketplace offers “one-stop shopping” to find and compare private health insurance options. In the marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductible, and out-of-pocket costs will be before you make a decision to enroll. You always have 60 days from the time you lose your job-based coverage to enroll in the marketplace. Coverage through the health insurance marketplace may cost less than COBRA continuation coverage. Through the marketplace you’ll also learn if you qualify for free or low cost coverage from Medicaid or Children's Health Insurance Program (CHIP). Being offered COBRA continuation coverage won’t limit your eligibility for coverage or for a tax credit through the marketplace. Should you have any questions about the health insurance marketplace, please visit www.healthcare.gov or call (800) 318-2596.
Notices

The Women’s Health and Cancer Rights Act

The Women’s Health and Cancer Rights Act of 1998 provides benefits for mastectomy-related services. These services include:

- Reconstructive surgery
- Surgery to achieve symmetry between the breasts
- Prostheses
- Physical complications resulting from a mastectomy (including lymphedema)

Please refer to your medical plan summary plan description for details, or contact your plan administrator for more information.
Contact Information

Auto Insurance*
MetLife Auto & Home
Geomara Polanco
AU Designated Agent
(703) 216-9675
www.metlife.com/mybenefits

Commuter Benefits*
ConnectYourCare
(877) 292-4040
www.connectyourcare.com

Counseling Resources*
AU Faculty Staff Assistance Program
(202) 885-2593
FSAP@american.edu

Dental
Delta Dental
(800) 932-0783
www.deltadentalins.com

Dependent Care / Family Services & Resources*
Bright Horizons
(877) 242-2737
www.careadvantage.com/au

Education Benefits*
AU Human Resources Benefits Team
(202) 885-3400
autuitionbenefits@american.edu

Flexible Spending Accounts
ConnectYourCare
(877) 292-4040
www.connectyourcare.com

Health and Wellness Programs for Faculty & Staff*
AhealthyU
(202) 885-3742
ahealthyu@american.edu

Home Insurance*
MetLife Auto & Home
Geomara Polanco
AU Designated Agent
(703) 216-9675
www.metlife.com/mybenefits

Legal Plan
Hyatt Legal’s MetLaw Plan
(800) 821-6400
www.legalplans.com

Life and AD&D Insurance
AU Human Resources Benefits Team
(202) 885-3400
myBenefits@american.edu

Legal Plan
Hyatt Legal’s MetLaw Plan
(800) 821-6400
www.legalplans.com

Medical
CareFirst
(800) 628-8549
www.carefirst.com

Pet Insurance*
MetLife
(800) USA-PETS
www.metlife.com/mybenefits

Prescription Drug
Express Scripts
(CareFirst Participants)
(877) 486-5984
www.express-scripts.com

Kaiser Permanente
(301) 468-6000
www.kaiserpermanente.org

Retirement Benefits*
Fidelity
(800) 343-0860
www.fidelity.com

TIAA
(800) 842-2252
www.tiaa.org

Short and Long Term Disability*
AU Human Resources Benefits Team
(202) 885-3400
myBenefits@american.edu

*Benefits that do not require election at open enrollment or upon new hire enrollment.