sjc St. John's College 2017 Benefits

St. John's College takes pride in offering a comprehensive and competitive benefits package to its employees. We, through all of our benefit partners, offer you a program that allows choice and flexibility. Through this program, you can choose the benefits that are best for you *and* your family.

Please take the time to review all plan options prior to making your selections. Consider each benefit and the associated cost carefully and choose the benefits package that will best meet your family's needs throughout the year.

The elections made during our open enrollment period will remain in place from January 1, 2017 through December 31, 2017. Options selected upon hire remain in place through the end of the plan year in which you are hired. The exception to both of these is a qualifying event. *Please see the table below for a description of what constitutes as a qualifying event.*

The Internal Revenue Service (*IRS*) states that eligible employees may only make elections to the plan at the time of hire and once a year at open enrollment. Medical, Dental and Vision benefit elections are binding through December 31 of each year. The following circumstances are reasons you may change your benefits during the year:

Marriage	***Death of a Spouse***
Divorce	***Death of a Dependent***
Birth & Adoption	***Loss of Dependent Status***
Loss of Spouse's job where coverage is maintained through a spouse's plan	

These special circumstances, often referred to as life event changes, allow you to make plan changes at any time during the year in which they occur. For any allowable change, **you must inform the Personnel Department within 30 days of the event** in order to make the change. All other changes are deferred to open enrollment.

INSIDE THIS GUIDE:

Medical Benefits

St. John's College's Medical plans are designed to provide you and your family with access to high quality healthcare. Review the plan options and select the plan that is right for you.

These Medical options cover a broad range of healthcare services and supplies, including prescriptions, office visits and hospitalizations. The plans differ when it comes to how they share costs with you.

Medical Benefits Plan Design

	Plan 1		Plan 2	
Loomis—Medical Plan Administrator (access the Cigna Network)	**Standard PPO Plan**		**HDHP w/ HSA**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Lifetime Maximum	**Unlimited**	**Unlimited**	**Unlimited**	**Unlimited**
Annual Deductible:	Embedded Deductible		Non-Embedded Deductible	
- Individual	$300	$1,000	$1,500	$3,000
- Family	$600	$2,000	$3,000 *(True Family Ded)*	$6,000 (*True Family Ded)*
Coinsurance	90%	70%	100%	70%
Out-of-Pocket Maximum *(includes Medical Deductibles, Medical and Rx Copays and Coinsurance)*				
- Individual	$2,000	$3,000	$3,000	$6,000
- Family	$4,000	$6,000	$6,000 (True Family OOP Max)	$12,000 (True Family OOP Max)
Office Visits				
Primary Care Physician	$15 Copay	Ded., then covered 70%	Ded., then $30 Copay	Ded, then covered 70%
Specialist Visits	$20 Copay	Ded., then covered 70%	Ded., then $50 Copay	Ded, then covered 70%
Preventive Services	Covered 100%	Ded., then covered 70%	Covered 100%	Ded, then covered 70%
Hospitalization				
- Outpatient Laboratory/Pathology	$20 Copay	Ded., then covered 70%	Ded., then covered 100%	Ded, then covered 70%
- Routine Radiology/X-Ray	$20 Copay	Ded., then covered 70%	Ded., then covered 100%	Ded, then covered 70%
- MRI/MRA, CT Scans/PET Scans	Ded., then covered 90%	Ded., then covered 70%	Ded., then $100 Copay	Ded, then covered 70%
- Emergency Room Care	$100 Copay, then covered 90% after Ded. (copay waived if admitted)		Ded., then $150 Copay (copay waived if admitted)	
- Urgent Care	$20 Copay	Ded., then covered 70%	Ded., then $30 Copay	Ded, then covered 70%
- Inpatient Hospital Care	$250 Copay, then covered 90% after Ded.	Ded., then covered 70%	Ded., then $250 Copay	Ded, then covered 70%
- Outpatient Surgery	Ded., then Covered 90%	Ded., then covered 70%	Ded., then $100 Copay	Ded, then covered 70%
- Durable Medical Equipment	Ded., then Covered 90%	Ded., then covered 70%	Ded., then covered 100%	Ded, then covered 70%
Prescription Drug				
Retail Copay (30-day supply)				
-Generic (Tier 1)	$10 Copay		Ded., then $10 Copay	
-Formulary (Tier 2)	$20 Copay		Ded., then $20 Copay	
-Non-Formulary (Tier 3)	$35 Copay		Ded., then $35 Copay	
Mail Order Copay (90-day supply)				
-Generic (Tier 1)	$20 Copay		Ded., then $20 Copay	
-Formulary (Tier 2)	$40 Copay		Ded., then $40 Copay	
-Non-Formulary (Tier 3)	$70 Copay		Ded., then $70 Copay	

The Prescription Drug Plan is administered by Loomis utilizing the CVS/Caremark Network

Medical High Deductible Health Plan/ Health Savings Account (HDHP/HSA)

The High Deductible Health Plan (HDHP) monthly cost is significantly lower than the Standard Plan because, as its name suggests, the HDHP features a higher deductible. HDHP enrollees are responsible for their health care expenses, other than preventive/wellness, up to the amount of the deductible.

A **Health Savings Account ("HSA")** is a type of **savings account** that allows you to save for medical expenses on a tax-free basis. An HSA is like an IRA plan for medical expenses; a tax-favored savings account established by you. The savings in your HSA are immediately available to you to pay for qualified medical, dental & vision expenses not covered by the plan. You may also choose to contribute to an HSA and save the funds for medical expenses in the future. Further, HSA funds are not subject to a *"use it or lose it"* policy. Any money you put into this account belongs to you.

The HDHP, together with the HSA, represents a different approach to health care. The plan concept, however, is simple:

- Carry a low cost, high deductible health plan instead of a higher priced plan with a lower deductible. As a result, your payroll contribution is less than the other plans.
- Contribute funds to your HSA on a pre-tax basis to use for medical, dental and vision expenses.
- What you do not use from the account each year remains in your account and continues to grow on a tax-favored basis for future expenses.
- The 2017 Annual Health Savings Account contribution limits are $3,400 (individual) and $6,750 (family). The 2017 Annual catch-up contribution for employees age 55-64 is $1,000.

Who is eligible to open a Health Savings Account?

Medical Plan Coverage	You must be enrolled in the HDHP through St. John's College
No Other Coverage	You may not have any other health plan coverage and that would include a medical spending Account (FSA). Those covered by a spouse's plan *(that is not a HDHP plan).* Medicare, Medicaid or Tricare are also not eligible to have a health savings account.
Other Benefits	You may not have received any Veterans Administration benefits in the last three months.
Dependent Status	You may not be claimed as a dependent on another person's tax return.

How an HDHP works

What happens to the money in my HSA at the end of the year?

Should you have funds left in your account at the end of the year, the money will rollover to the next year. This is true even if you select another health plan at the next open enrollment, but in order to contribute to the account, you must remain enrolled in a qualified HDHP medical plan.

In addition, you retain your account even if you leave your employer. The money in your account can continue to grow to help cover future health care expenses. **Please note that should you withdraw the money for anything other than eligible health care expenses, you must pay income tax and a 20% penalty.**

Medical Plan Definitions

Deductible - The deductible is the amount of your covered expenses you must pay each policy year before the insurance company begins to pay.

Embedded Deductible - An embedded deductible is applicable when you are covering any dependents. Once an individual family member pays the individual deductible, insurance begins to pay for medical expense associated with the individual's services even if the family deductible has not been met. **This applies to the Standard PPO plan.**

Non-Embedded Deductible - Also referred to as a "True" Family Deductible. There is not an individual deductible embedded in the family deductible. Before the plan helps you pay for any of your medical bills, the entire amount of the family deductible must be met first. It can be met by one family member or a combination of family members. Once the family deductible is met, the plan will pay benefits for all family members. **This applies to the HDHP plan.**

Coinsurance - After the deductible is met, you and the plan will share in the payment of your healthcare related bills. The coinsurance amount will depend on the plan you choose and whether in-network or out-of-network providers are utilized.

Copayment - Copayment refers to a fixed cost that you must pay per occurrence. Copayments are paid directly to the providers (i.e. physician or pharmacy).

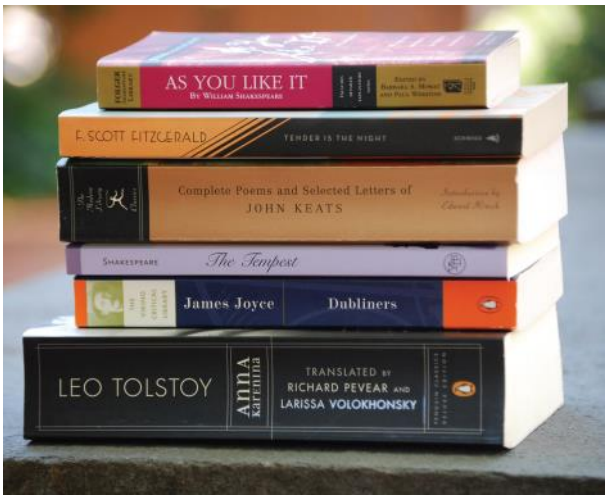
Explanation of Benefits (EOB) - An explanation of benefits is a statement sent by the plan to explain what medical treatments and/or services were paid for on your behalf. These are not bills, so no payment is required; however, it's important to review your EOBs to gain a better understanding of the services paid for and the cost of care.

Formulary – A list that contains the approved medications that are part of your prescription drug plan.

Generic – An FDA-approved drug, composed of virtually the same chemical formula as a brand-name drug.

Out-of-Pocket Maximum - This maximum limits your out-of-pocket expenses (including deductible, coinsurance and all copays) in any one policy year. If you reach the out-of-pocket maximum, the plan pays 100% of the person's or family's covered expenses for the remainder of the year.

Covered Expenses - Covered expenses are the expenses that are eligible for reimbursement. All the plans generally provide benefits for medically necessary services and supplies ordered by a doctor or dentist. Each option also provides benefits for certain routine and preventive services. Under all plans, when benefits are paid for out-of-pocket covered expenses, Loomis will consider payment of those expenses only up to the Reasonable & Customary (R&C) limits.



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https://apps.cignabehavioral.com/web/consumer.do#/consumer

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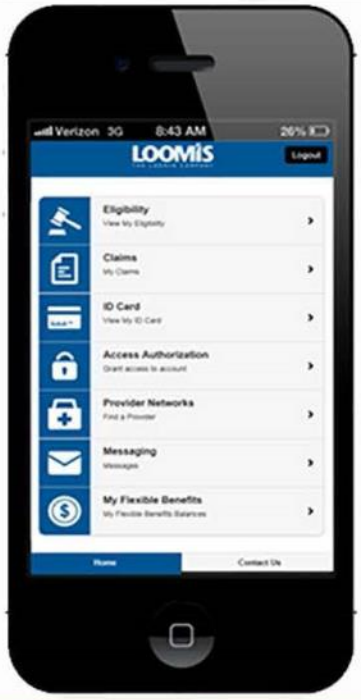

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Dental Benefits

Good dental health is important to your overall well-being. At the same time, we all need different levels of dental treatment. MetLife's dental plan provides affordable coverage based on the type of services obtained – **Preventive, Basic or Major** and whether or not you obtain services from a network or non-network provider.

MetLife allows employees the freedom to select the dentist of their choice. When you elect an in-network provider, your plan benefits are based on the percentage of the negotiated fee– the fee that the participating dentists have agreed to accept as payment in full for covered services.

If you elect an out-of-network provider, your out-of-pocket expenses may be higher, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service. Out-of-network dentists can balance bill you for services. *

A complete provider directory can be accessed online at www.metlife.com.

Coverage Type	MetLife Dental Benefits	
	In-Network	Out-of-Network
Balance Billing*	No	Yes
Deductible		
Individual	$50	$50
Family	$100	$100
Preventive	Deductible Waived	
	100%	Out-of-network dentist can bill you for anything over the amount that MetLife recognizes or allows at the in-network level.
Basic Services	Deductible First	
	80%	Out-of-network dentist can bill you for anything over the amount that MetLife recognizes or allows at the in-network level.
Major Services	Deductible First	
	50%	Out-of-network dentist can bill you for anything over the amount that MetLife recognizes or allows at the in-network level.
Calendar Year Max	$1,500 (excludes orthodontia)	
Orthodontia (up to age 19)	50%	Out-of-network dentist can bill you for anything over the amount that MetLife recognizes or allows at the in-network level.
Lifetime Orthodontia Max	$1,000	
Rates	**Monthly**	**Bi– Weekly**
Employee Only Employee + 1 Dep Employee + 2 or More Deps	$40.67 $82.28 $149.94	$18.77 $37.98 $69.20

Vision Benefits

The EyeMed Vision Plan offers participants a comprehensive benefit. The office visit copay for an eye exam is $10.

Participants have the option of receiving care from an EyeMed Vision Provider or a Non-EyeMed provider; however, if you use an out of network provider, you will incur higher out-of-pocket expenses.

A complete provider directory can be accessed online at www.eyemedvisioncare.com.

Coverage Type	EyeMed Vision Benefits	
Benefits	**In-Network**	**Out-of-Network**
Exam	$10 Copay	Reimbursed up to $30
Single Vision Lenses	$25 Copay	Reimbursed up to $25
Bifocal Lenses	$25 Copay	Reimbursed up to $40
Trifocal Lenses	$25 Copay	Reimbursed up to $60
Contact Lenses (materials only)	**Conventional:** $0 Copay; $130 allowance, 15% off balance over $130 **Medically Necessary**: Covered in full	**Conventional:** reimbursed up to $104 **Medically Necessary**: up to $200
Frames	$0 Copay; $130 Allowance, 80% charge over $130	Reimbursed up to $65
Frequency		
Examination Lenses or Contact Lenses Frame	Once every 12 months Once every 12 months Once every 24 months	
Rates	**Monthly**	**Bi-weekly**
Employee Only Employee + Child(ren) Employee + Spouse Family	$5.46 $10.93 $10.38 $16.06	$2.52 $5.04 $4.79 $7.41

Basic Life and Accidental Death & Dismemberment Insurance

St. John's College provides all eligible employees with a $50,000 flat term Life and Accidental Death Insurance plan. The premiums for this plan are paid in full by the College. You may purchase additional Supplemental life insurance from a minimum of $50,000 to a maximum of $300,000 in $50,000 increments. A Voluntary AD&D plan is also available.

Short Term Disability Insurance

After one year of benefit eligibility, St. John's College provides each eligible employee with a short term disability plan, which provides benefits for the first six months of total disability (meaning total inability to perform one's job). Approved disability benefits continue up to six months from the date total disability began or until the employee is no longer disabled whichever comes first. The benefit covers 100% of the employee's current salary for the first four months and 80% of salary for the next two months. To receive benefits a claim form is required to be filed within 14 days of the onset of the disability.

Long Term Disability Insurance

The benefit covers 60% of the employee's monthly compensation minus income from other sources, upon 180 consecutive days of total disability. The monthly maximum benefit is $6,000. Premiums are paid by employees on an after tax basis and the coverage will provide a tax-exempt benefit. The monthly rate is $.31/$100 of monthly covered payroll. The maximum monthly covered payroll is $10,000.

Voluntary Life - Employee Only Coverage

Employee Coverage: Guarantee Issue - $150,000; $50,000 increments to a maximum $300,000

Employee Monthly Premiums

Benefit Amount	Age 18-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$50,000	$2.00	$2.50	$3.50	$4.00	$4.00	$6.50	$9.50	$18.00	$28.00	$53.50	$87.00
$100,000	$4.00	$5.00	$7.00	$8.00	$8.00	$13.00	$19.00	$36.00	$56.00	$107.00	$174.00
$150,000	$6.00	$7.50	$10.50	$12.00	$12.00	$19.50	$28.50	$54.00	$84.00	$160.50	$261.00
$200,000	$8.00	$10.00	$14.00	$16.00	$16.00	$26.00	$38.00	$72.00	$112.00	$214.00	$348.00
$250,000	$10.00	$12.50	$17.50	$20.00	$20.00	$32.50	$47.50	$90.00	$140.00	$267.50	$435.00
$300,000	$12.00	$15.00	$21.00	$24.00	$24.00	$39.00	$57.00	$108.00	$168.00	$321.00	$522.00

Converting monthly rates to bi-weekly deductions: monthly rates x 12 divide by 26

Voluntary AD&D Coverage

Employee Coverage: Minimum of $25,000 to a maximum of $125,000 in $25,000 increments

Spouse and Child(ren) Coverage:

- Spouse with no child(ren): 50% of the employee amount
- Spouse with child(ren): 40% of the employee amount
- Child(ren) with spouse: 10% of the employee amount
- Child(ren) with no spouse: 15% of the employee amount

Monthly Premiums

Benefit Amount	Employee	Family
$25,000	$0.50	$0.75
$50,000	$1.00	$1.50
$75,000	$1.50	$2.25
$100,000	$2.00	$3.00
$125,000	$2.50	$3.75

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Employee Assistance Benefits

The EAP through Business Health Services provides up to six free, confidential counseling visits per episode per year to employees and their household members who need short term assistance with financial, marital/family issues, stress, emotional difficulties, or alcohol/drug problems. Call (800) 327-2251 to schedule an appointment or visit the EAP website at www.bhsonline.com for articles on a wide variety of topics. Our user name is JOHN.

Flexible Spending Account

St. John's College allows you to defer a portion of your pay through payroll deduction into Flexible Spending Accounts. The money that goes into an FSA is deducted on a pre-tax basis, which means it is taken from your pay before Federal and Social Security taxes are calculated. Because you do not pay income taxes on money that goes into your FSA, you decrease your taxable income.

Note—If you open a Health Savings Account, you are not eligible to enroll in the Health Care FSA

Medical FSA: You may deposit up to **$2,500** per plan year into your Medical FSA to cover you and your dependents during the plan year. Eligible expenses include, but are not limited to, deductibles, co-payments and co-insurance payments, routine physicals, uninsured dental expenses, vision care expenses and hearing expenses.

Dependent Care FSA: You may deposit up to **$5,000** per plan year into your Dependent Care FSA. Eligible expenses include payments to day care centers, preschool costs, before and after school care and elder care.

403(b) Tax Deferred Annuity

St. John's College offers a 403(b) tax deferred annuity to all employees. The plan is administered by TIAA-CREF and consists of a retirement annuity (to which the College makes contributions; check the appropriate plan document for details) and a supplemental retirement annuity (to which only employees make contributions). Forms can be located on the Shared Drive or by visiting the Personnel Department.

Compliance Notices

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself andor your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

NON-MEDICAL

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or CHIP.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

IMPORTANT NOTICE FROM ST. JOHN'S COLLEGE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with St. John's College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Compliance Notices (continued)

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. St. John's College has determined that the prescription drug coverage offered by United HealthCare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current **St. John's College** coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current **St. John's College** coverage, be aware that you and your dependents may be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **St. John's College** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.
For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **St. John's College** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

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

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

Date:	**October 1, 2017**
Name of Entity/Sender:	**St. John's College**
Address:	**60 College Avenue, Annapolis, MD 21401**
Phone Number:	**410-626-2896**

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	KENTUCKY – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ALASKA – Medicaid	**LOUISIANA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
ARKANSAS – Medicaid	**MAINE – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
COLORADO – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
FLORIDA – Medicaid	**MINNESOTA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739
GEORGIA – Medicaid	**MISSOURI – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
INDIANA – Medicaid	**MONTANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
IOWA – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid	SOUTH DAKOTA - Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	**TEXAS – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	**VERMONT– Medicaid**
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
OKLAHOMA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
OREGON – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
PENNSYLVANIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
RHODE ISLAND – Medicaid	**WYOMING – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
SOUTH CAROLINA – Medicaid	
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

If you have questions about...	Vendor	Phone Number	Email/Website
Medical PPO Network Name: Cigna PPO Wrap PPO Network Name (if traveling or away at school: MultiPlan Forward ALL Claims to: PO Box 188061 Chattanooga, TN 37422-8061 Electronic Payer ID# 62308	Loomis	800-875-2364 (Group #: F10142)	www.loomisco.com
Prescription Benefits Caremark RXClaim: - RXBIN: 004336 - RXPCN: ADV - RXGRP: RX2637	CVS Caremark	1-866-475-0056	www.caremark.com
Dental Benefits	MetLife	1-800-275-4638 (Group #: TS-05326199-G)	www.metlife.com
Vision Benefits	EyeMed	1-866-299-1358 (Group #: VC-19)	www.eyemedvisioncare.com
Flexible Spending Account	Loomis	1-800-253-5998	flexclaims@loomisco.com
Employee Assistance Program (EAP)	Business Health Services	1-800-327-2251	Bhsonline.com Username: John
COBRA	Sarah Keener—Loomis	610-374-4040 ext. 2459	skeener@loomisco.com
Utilization Review and Pre-notification	Cigna	1-800-875-2364	
Retirement—403(b)	TIAA-CREF	1-800-842-7782	

Personnel Department Contact

Lynn Hobbs
Email: Lynn.Hobbs@sjc.edu
Phone: 410-626-2504

This benefits summary describes the highlights of our benefits in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in the materials and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information.