2022 Employee Benefit Guide

Associated Students, Inc.

HELPING YOU MAKE INFORMED CHOICES ABOUT YOUR EMPLOYEE BENEFITS

ABOUT THIS GUIDE

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice.

Great care has been taken to ensure this guide is accurate. However, oversights can occur or condensed summaries can be misinterpreted. If there is a difference between this overview and the official plan documents governing the plans, the plan documents will prevail. In the event of a discrepancy between this booklet and the EOC, the EOC will prevail.

Making Changes to Your Benefits

During Open Enrollment you can change your benefit choices. Open Enrollment changes will be effective July 1st. Your decisions remain in effect for twelve months unless you have a qualifying life event as defined by the IRS;

- The addition of a dependent through marriage, adoption or birth.
- The loss of other "group" coverage.
- The loss of a dependent through divorce or death, or if your child reaches the maximum age limit for coverage.
- A change in your or your spouse's employment status from full-time to part-time or vice versa.
- A substantial change in your benefits coverage or a spouse's coverage.
- The addition or separation of a qualified domestic partner.
- Change in eligibility for Medicaid or Children's Health Insurance Program (CHIP) subsidy.

Any benefit changes must be consistent with the type of event you experience. If you add a dependent, you can add them to your benefits, but you cannot drop another dependent from benefits. For example, if you have a baby, you can add the baby to your medical plan, but you cannot drop a spouse from the plan. If you experience a family status change and want to change your benefits, you MUST contact Human Resources **within 30 days of the change.**

Eligibility for Benefits

Benefit eligible employees will become eligible for benefits first of the month following eligible employment. The following family members may also be enrolled in the group benefits as noted below:

- Your legal spouse
- Your qualified domestic partner
- Your children until age 26 (medical)
- Your qualified domestic partner's children until age 26 (medical)
- Your dependent child who is incapable of self support because of a mental or physical disability

For the purpose of our benefit plans, your children include:

- Natural and adopted children
- Stepchildren
- Any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order.

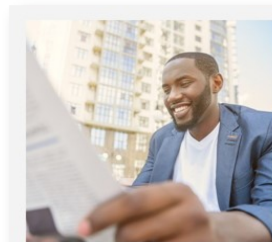


TABLE OF CONTENTS

TABLE OF CONTENTS

About This Guide.. 1

Table of Contents 2

Contact Information 3

Kaiser Permanente Medical Plan 4

Sutter Health Plus Medical Plan 5

Important Information about Medical Plans.. 6

MetLife Dental Plan 7

Additional Dental Information 8

MetLife Vision Plan 9

MetLife Basic Life and AD&D 10

MetLife Long Term Disability 10

MetLife Voluntary Life and AD&D................ 11

MetLaw Voluntary Legal 12

Pet Insurance 13-14

Employee Assistance Program 15

Flexible Spending Plan 16

Dependent Care Reimbursement................ 16

Monthly Payroll Deductions—40 Hours 17

Monthly Payroll Deductions—30 Hours 18

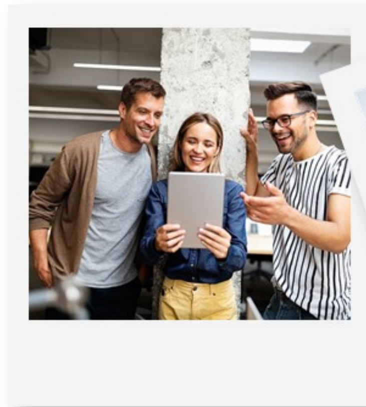
Glossary of Key Terms 19

2022—2023 Annual Notices 20-30

"Individual Mandate: Make Sure You're Covered"

As of January 1, 2014, the Affordable Care Act — also known as "healthcare reform" — requires you and your dependents to have health insurance (unless you meet certain exceptions). You can meet this requirement by enrolling in a Associated Students, Inc. plan, purchasing coverage in the Marketplace Exchange or if you have Medicare or Medical. If you do not have health insurance, you may pay a tax penalty when you file your taxes at the end of the year.

Associated Students, Inc.'s medical plan options provide valuable comprehensive coverage that meets the requirements of the healthcare reform law and is intended to be affordable as defined by the law. It is unlikely that you are eligible for financial assistance from the government to help you pay for insurance purchased through the Market-place because you have access to an employer plan that complies with the affordability standard. All enrollment and eligibility matters should be directed to the Human Resources Department at Associated Students, Inc.



CONTACT INFORMATION

The quickest way to find answers to your benefit questions is to go directly to the source. This contact list includes web addresses and phone numbers for the administrators of each of our benefit plans. The insurance company can verify benefits and coverage or copayment information. We suggest you contact the insurance company prior to seeking care should you have any questions in regards to your benefits.

PLAN	MEMBER SERVICES	WEBSITE	GROUP NO.
MEDICAL			
Kaiser	800-464-4000	www.kp.org	1468
Kaiser Chiropractic (ASH)	800-678-9133 Call for Provider List		
Sutter Health Plus	855-315-5800	www.sutterhealthplus.org	252211
Sutter Health Plus Acu/Chiro (ACN Group of CA)	800-428-6337		
VSP as part of Sutter Health Plus Medical Plan	800-877-7195		
DENTAL			
MetLife	800-ASK-4MET (800-275-4638)	www.MetLife.com	KM05952749
VISION			
MetLife	800-ASK-4MET (800-275-4638)	www.MetLife.com	KM05952749
LIFE AND AD&D			
MetLife	800-638-5000	www.MetLife.com	KM05952749
LONG TERM DISABILITY			
MetLife	800-929-1492	www.MetLife.com	KM05952749
LEGAL			
MetLaw	800-821-6400	info.legalplans.com Access Code: GETLAW	
EMPLOYEE ASSISTANCE PLAN			
LifeWorks	888-319-7819	www.metlifeeap.lifeworks.com	
FLEXIBLE SPENDING ACCOUNT / DEPENDENT CARE REIMBURSEMENT			
Workterra	888-327-2770	https://workterra.lh1ondemand.com	
PET INSURANCE			
MetLife	855-270-7387		
403(B) RETIREMENT PLAN			
Voya Financial	800-584-6001	www.voyaretirement.voya.com	664FB1
ASI HUMAN RESOURCES			
Myra Makelim	916-278-5484	makelim@csus.edu	

MEDICAL BENEFITS—KAISER PERMANENTE

Administered by Kaiser Permanente

We offer employees a choice of medical plans through Kaiser and Sutter Health Plus. This page provides information on the Kaiser plan. Services with the HMO plan must be obtained from a participating provider or hospital. Select a doctor at a Kaiser facility near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Most Kaiser locations offer multiple services under one roof. That means you may be able to see your PCP, get an X-ray, visit the lab and fill your prescription all in the same place.

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$2,500
Family (two or more Members)	$5,000
DEDUCTIBLE	
Individual and Family (two or more Members)	None
PREVENTIVE SERVICES	
Routine Preventive Care / Physical Examinations	No Charge
Well-Child Visits	No Charge
Prenatal Care Visits and First Postpartum Visit	No Charge
PROFESSIONAL SERVICES	
Primary & Specialty Care Visits	$30
Physical, Occupational and Speech Therapy	$30
OUTPATIENT SERVICES	
Outpatient Surgery / Outpatient Procedures	$250 per procedure
Lab / X-Ray	$10 per encounter
MRI, CT Scans, PET Scans	$50 per procedure
Chiropractic	$15 (30 visits/yr)
Vision Exam/Lenses	No Charge
Frames (every 24 months) / Contact lenses (every 12 months)	$150 allowance
HOSPITALIZATION	
Room and Board, Surgery, Anesthesia	$500 per admission
Emergency Room	$100 per visit
Ambulance Services	$100 per trip
PRESCRIPTION DRUG SERVICES (RETAIL—30 DAY SUPPLY)	
Generic Prescriptions	$15
Brand Name Prescriptions	$35
Specialty Prescriptions	30% up to $200 max
Mail Order	2x retail cost for 100 day supply

MEDICAL BENEFITS—SUTTER HEALTH PLUS

Administered by Sutter Health Plus

This page provides information on the Sutter Health Plus. As a member of Sutter Health Plus, you have access to a large network of Participating Providers from which to choose your Primary Care Physician (PCP). All non-Emergency care must be accessed through your PCP, with the exception of OB/GYN services and annual vision exams, which may be obtained through direct access without a referral.

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$2,000
Family (two or more Members)	$4,000
DEDUCTIBLE	
Individual and Family (two or more Members)	None
PREVENTIVE SERVICES	
Routine Preventive Care / Physical Examinations	No Charge
Well-Child Visits	No Charge
Prenatal Care Visits and First Postpartum Visit	No Charge
PROFESSIONAL SERVICES	
Primary & Specialty Care Visits	$30 per visit
Urgent Care	$40 per visit
OUTPATIENT SERVICES	
Outpatient Surgery / Outpatient Procedures	$100 per visit
Lab / X-Ray	$10 per encounter
MRI, CT Scans, PET Scans	$50 per procedure
Chiropractic	$15 (30 visits/yr)
Vision Exam / Materials (every 12 months)	No Charge for Exam / $20 copay for Materials
Frames / Contact Lens (every 24 months)	$120 Allowance
HOSPITALIZATION	
Room and Board, Surgery, Anesthesia	$500 per admission
Emergency Room	$150 per visit
Ambulance Services	$100 per trip
PRESCRIPTION DRUG SERVICES (RETAIL—30 DAY SUPPLY)	
Tier 1	$10
Tier 2	$30
Tier 3	$60
Tier 4—Specialty Pharmacy	20% coinsurance up to $100 max
Mail Order	2x retail cost for 100 day supply

IMPORTANT INFORMATION ABOUT MEDICAL PLANS

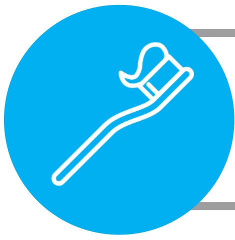
Patient Protection Disclosure

Kaiser and Sutter Health Plus generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser or Sutter Health Plus. You may designate a pediatrician as the primary care provider for children.

You do not need prior authorization from your Insurance Carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser or Sutter Health Plus.

Medical Annual Out of Pocket Maximums

The plans have embedded deductibles and out-of-pocket maximums. Each family member will begin paying copays or coinsurance after meeting his/her individual deductible, or when the family deductible is satisfied. Individual family members are no longer subject to the cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.



DENTAL BENEFITS

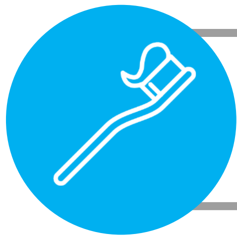
Administered by MetLife

With all of the emphasis on healthy living, it is important to have access to a comprehensive dental plan that makes it easier for you and your family to maintain a healthy regimen while helping to protect you against the rising costs of dental care.

MetLife offers you 2 levels of dental providers, contracted Providers (In-Network) & Non-Contracted (Out-of-Network) providers. When you visit a dentist who participates in the MetLife Dental PPO Network, you can save an average of up to 30 percent (see page 8 for sample costs). The PPO network is nationwide so you can find a participating dentist near your home, work, when you're on vacation or away at college.

PLAN DESIGN		
	In Network (PDP Plus Network)	**Out of Network***
Calendar Year Benefit Maximum	$2,000 per person	$2,000 per person
Calendar Year Deductible	$25 Individual $75 Family	$50 Individual $150 Family
PREVENTIVE:		
Routine Oral Exams Bitewing X-Ray Full-mouth X-Rays Routine Oral Exams Cleanings -2/year Fluoride (children) Space Maintainers for children Sealants for children	100% Deductible waived	100%* Deductible waived
BASIC SERVICES:		
Palliative Treatment Fillings Simple Extractions Surgical Extractions Oral Surgery Endodontics (Root Canals) Periodontics	90% Subject to deductible	80%* Subject to deductible
MAJOR SERVICES:		
Crowns, Inlays, Onlays Bridges Dentures Occlusal Adjustments General Anesthesia	60% Subject to deductible	50%* Subject to deductible
ORTHODONTIA - ADULTS & CHILDREN	50%	50%
ORTHODONTIA LIFETIME MAXIMUM	$2,000 per person	$2,000 per person

*Covered charges for out-of-network are based on the lower of:
1) The dentists actual charge for the service, or 2) The dentists usual charge for the service, or
3) The UCR amount of the service based on the 90th percentile of dentists in the same geographic area.



DENTAL BENEFITS

How To Find a Participating Provider

Go to www.MetLife.com anytime and where it says "I want to find a MetLife:" select "Dentist." You can also call 1-800-Ask-4Met. A MetLife customer care specialist will be happy to help you.

Refer Your Dentist

If your dentist doesn't participate, please help us get your dentist in our PPO network. That way, you can continue to see the dentist you know and trust while receiving the best value from your plan.

Pre-determination of Benefits

If dental services are expected to excess $300, we encourage you to obtain a "pre-determination of benefits." Your dentist office can submit this request for you to the carrier prior to receiving services. This will give you an estimate of what your out-of-pocket costs will be in advance of having the procedure performed.

Out of Network Provider's

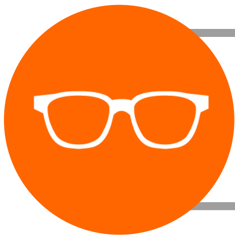
Non-participating dentists can bill you for charges above the amount covered by your MetLife Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Sample Scenarios - In Network vs Out of Network

The scenario below reflects charges for a crown that are paid at 60%. The charges and reimbursement limits in this scenario are fictitious; however, they illustrate the difference between the two reimbursement limit options. The coinsurance levels for this plan differ by the type of service:

- Preventive service – 100 percent
- Basic service – 80 percent
- Major service – 50 percent

Example	MetLife Contracted In-Network Dentist	Out of Network Non-Contracted Dentist
Dentist's charge for crown	$1,000	$1,000
Sample plan allowance Based on:	$640 PPO plan allowance	$700 Plan allowance
Coinsurance amount	60%	50%
Plan payment	$320	$350
Balance billing	No	Yes: $300
Enrollee payment	($640 x 40%) = $256	($700 x 50%) + $300 (difference between allowed and actual charges) = $650



VISION BENEFITS

Administered by MetLife

Establishing a relationship with your eye doctor is important. They can see differences in your vision and overall eye health. Annual eye exams are important to your overall health. During your eye exam, your eye care provider will look for vision problems and signs of other health conditions like diabetes, high blood pressure, and high cholesterol.

This plan provides coverage for annual eye examinations as well as materials (lenses, frame and/or contacts).

MetLife offers you 2 levels of vision providers, contracted providers (In-Network) & non-contracted (Out-of-Network) providers. When you visit a provider who participates in the MetLife PPO Network, you can save. The PPO network is nationwide so you can find a participating provider near your home, work, when you're on vacation or away at college. When you visit an out-of-network provider, you will have to pay the full cost of the visit and then submit your receipts for reimbursement.

PLAN DESIGN		
	In-Network	**Out-of-Network**
EYE EXAMINATION	**Once every 12 months**	
COPAY	$10 copay	$45 allowance
LENSES	**Once every 12 months**	
Benefit: Single Vision Lenses Bifocal Vision Lenses Trifocal Vision Lenses Lenticular	 $10 copay $10 copay $10 copay $10 copay	Reimbursed as follows: $30 allowance $50 allowance $65 allowance $100 allowance
STANDARD LENS ENHANCEMENT		
UV Coating Polycarbonate (children)	Covered in full Covered in full	Applied to allowance for the applicable corrective lens
ADDITIONAL LENS ENHANCEMENT		
Progressive Standard Progressive Premium Polycarbonate (adult) Scratch-resistant coating Tints Anti-reflective coating Photochromic	Up to $55 copay $95 to $175 copay Up to $31 to $35 copay Up to $17 to $33 copay Up to $17 to $44 copay Up to $41 to $85 copay Up to $47 to $82 copay	$50 allowance $50 allowance Applied to allowance for the applicable corrective lens
FRAME	**Once every 24 months**	
Retail Benefit Costco Wholesale Benefit	$130 allowance + 20% off $70 allowance	$70 allowance
CONTACT LENSES (IN LIEU OF GLASSES)	**Once every 12 months**	
Elective Contacts Medically Necessary Contact Fitting and Evaluation	$130 allowance $10 copay Max $60 copay	$105 allowance $210 allowance Applied to the contact lens allowance

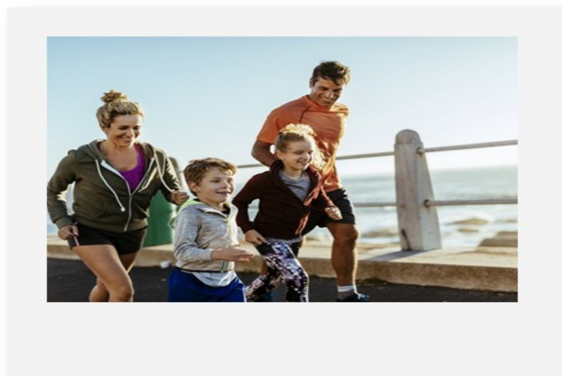
BASIC LIFE/AD&D AND LONG TERM DISABILITY

Basic Life with Accidental Death & Dismemberment and Long Term Disability coverages are provided to employees working at least 40 hours per week by your employer at no cost to you. These coverages provide some financial security to you and your dependents in the event something happens to you. MetLife insures these benefits. Please refer to your certificate of coverage for complete detail of benefits.

Enrollment is automatic, but it is your responsibility to complete and update your beneficiary designation form as needed. Visit www.MetLife.com or call 800-275-4638

MetLife Life and AD&D	
Basic Life Benefit	Flat $50,000
Your AD&D Benefit	Equal to your Basic Life Benefit
Reduction Schedule	Benefits will reduce 35% at age 70, and 50% at age 75
Conversion	You may convert this policy to an individual policy upon termination of your employer provided coverage. You have 31 days from termination to convert your policy. Contact MetLife for details and rates.
Beneficiary Designation	**It is your responsibility to ensure that your beneficiary information is correct. If you experience a life event change, contact Human Resources to update your beneficiary.**

MetLife Long Term Disability	
Long Term Disability Benefit	66.67% of your pre-disability monthly earnings
Maximum Monthly Benefit	$3,000 per month
Elimination Period	90 days
Pre-existing Conditions	3 months prior to and 12 months after the effective date

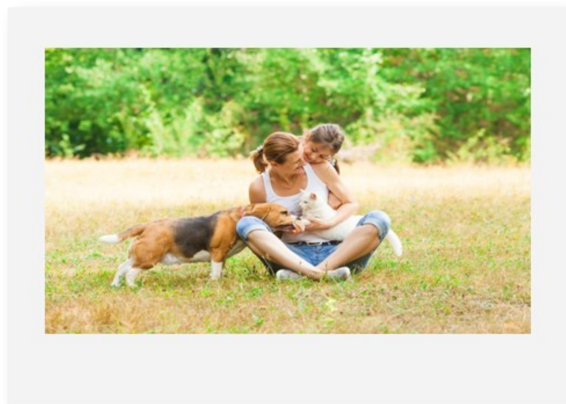


VOLUNTARY LIFE/ AD&D

Voluntary Life with Accidental Death & Dismemberment coverage are offered to you on a voluntary basis. These coverages provide some financial security to you and your dependents in the event something happens to you. MetLife insures this benefit. Please refer to your certificate of coverage for complete detail of benefits. Inquire with Human Resources for rates.

Visit www.MetLife.com or call 800-275-4638

MetLife Voluntary Life and AD&D	
Supplemental Term Life Coverage	**Employee**: $10,000 increments up to 5 times annual salary up to $300,000 **Spouse**: $5,000 increments, not to exceed 50% of the employee's benefit amount up to $100,000 **Dependent Children**: Flat amount: $1,000; $2,000; $4,000; $5,000; or $10,000
Guarantee Issue for Newly Eligible Employees Only; *Current employees subject to evidence of insurability and subject to approval by MetLife*	**Employee**: $150,000 **Spouse**: $25,000 **Child**: $10,000
Your AD&D Benefit	Benefit amount is equal to supplemental term life coverage
Reduction Schedule	None
Portability	You may port this policy to an individual policy upon termination of your employer provided coverage. You have 31 days from termination to convert your policy. Contact MetLife for details and rates.
Beneficiary Designation	**It is your responsibility to ensure that your beneficiary information is correct. If you experience a life event change, contact Human Resources to update your beneficiary.**



MetLaw®

Smart. Simple. Affordable.®

Telephone & Office Consultations

MetLaw 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.

Legal Representation

Estate Planning

- Simple Wills
- Complex Wills
- Revocable Trusts
- Irrevocable Trusts
- Powers of Attorney (healthcare, financial, childcare)
- Healthcare Proxies
- Living Wills
- Codicils

Money Matters

- Personal Bankruptcy/Wage Earner Plan
- Debt Collection Defense
- Foreclosure Defense
- Repossession Defense
- Garnishment Defense
- Identity Theft Defense
- Tax Collection Defense
- Negotiations with Creditors
- Tax Audit Representation (Municipal, State, Federal)

Real Estate Matters

- Sale, Purchase or Refinancing of primary, second or vacation home
- Home Equity Loans for primary, second or vacation home
- Eviction & Tenant Problems (for tenant)
- Security Deposit Assistance (for tenant)
- Boundary or Title Disputes
- Property Tax Assessments
- Zoning Applications

Elder Law Matters

Consultation & Document Review for issues related to your parents:

- Medicare
- Medicaid
- Prescription Plans
- Nursing Home Agreements
- Leases
- Notes
- Deeds
- Wills
- Powers of Attorney

Family Law

- Adoption & Legitimization
- Guardianship
- Conservatorship
- Name Change
- Prenuptial Agreement
- Protection from Domestic Violence

Traffic Offenses*

- Defense of Traffic Tickets (excludes DUI)
- Driving Privileges Restoration (includes License Suspension due to DUI)

Document Preparation

- Affidavits
- Deeds
- Demand Letters
- Mortgages
- Promissory Notes
- Review of Any Personal Legal Document

Immigration Assistance

- Advice & Consultation
- Review of Immigration Documents
- Preparation of Affidavits
- Preparation of Powers of Attorney

Juvenile Matters

- Juvenile Court Defense (includes Criminal Matters)
- Parental Responsibility Matters

Consumer Protection

- Disputes over Consumer Goods & Services
- Small Claims Assistance

Defense of Civil Lawsuits

- Civil Litigation Defense
- Incompetency Defense
- Administrative Hearings
- School Hearings
- Pet Liabilities

Personal Property Protection

- Consultation & Document Review for personal property issues
- Assistance for disputes over goods & services

For More Information:

Visit **info.legalplans.com** and enter access code GETLAW or call our Client Service Center at 800-821-6400 (Monday – Friday, 8 am to 7 pm EST/EDT).

$19.50 per month

covers employee, spouse and dependents

The cost is automatically deducted from your paycheck.

Additional Plan Features

Reduced Fees

Network attorneys provide representation for personal injury, probate & estate administration matters at reduced fees.

Family Matters™**

Available for an additional fee. Separate plan for parents of participants for estate planning documents.

E-Services

Attorney Locator; Law Firm E-Panel®; Free, downloadable legal documents; Life Guide; Links to financial planning, insurance & work/life matters resources

Smart. Simple. Affordable.®

Hyatt Legal Plans

A MetLife Company

Group Legal Plans and Family Matters are provided by Hyatt Legal Plans, Inc., a MetLife company, Cleveland, Ohio. In certain states, group legal plans and Family Matters are provided through insurance coverage underwritten by Metropolitan Property and Casualty Company and Affiliates, Warwick, Rhode Island. Please contact Hyatt Legal Plans for complete details on covered services including trials. No service, including advice and consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the company, MetLife and affiliates, and Plan Attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm matters, business or investment matters, matters involving property held for investment or rental, or issues when the Participant is the landlord; 6) patent, trademark and copyright matters; 7) costs or fines; 8) frivolous or unethical matters; 9) matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters listed above under Legal Representation. *Not available in all states. **For Family Matters, different terms and exclusions apply. L0316460711[exp0517][All States][DC,PR]

MetLife

A Fetching Value Added Benefit

Top-quality talent requires top-quality benefits. With over 85 million U.S. families owning a pet,[1] a high percentage of your employees are likely to come home to a beloved cat or dog after they work for the day. MetLife makes it easy to add Pet Insurance to your benefits program.

Available to businesses from 51–99 employees, you will automatically be able to offer a discounted pet insurance program to your employees when you add any other MetLife core coverage. And there's no additional cost or work involved as MetLife works directly with your employees for enrollment, servicing and billing. Employees will be instructed to enroll online or by phone. By offering pet coverage, you can stand apart from the competition and make your benefits package more attractive.

73% of millennial pet parents would go into debt to provide for their pets' wellbeing[3]

62% of millennial pet parents say they would put their pet's health before their own[4]

58% of employees would choose a pet-friendly employer over an employer who is not[5]

24% of pet parents have gone into credit card or personal loan debt as a result of health/vet costs for their pet[6]

About Pet Insurance Offered By MetLife[1]

Flexible product offerings with straightforward pricing and options, customizable limits and deductible savings[7]

Quick 3-step enrollment and hassle-free claims experience with most claims processed within 10 days[8]

Multichannel support options with an experienced team of pet advocates that have been serving pet parents and their communities for more than 15 years

5%

Group discount employees receive a 5% group discount[9]

[1]According to the 2019-2020 National Pet Owners Survey conducted by the American Pet Products Association (APPA).
[2] Independence American Insurance Company ("IAIC") is the insurance carrier for this product. PetFirst Healthcare, LLC, a MetLife company, is the policy administrator authorized to offer and administer pet insurance policies. Independence American Insurance Company, a Delaware insurance company, is headquartered at 485 Madison Avenue, NY, NY 10022. For costs, complete details of coverage and exclusions, and a listing of approved states, please contact PetFirst Healthcare, LLC. Like most insurance policies, insurance policies issued by IAIC contain certain exclusions, exceptions, reductions, limitations, and terms for keeping them in force.
[3]2019 Employee Benefit Adviser "5 benefit perks to entice top millennial talent to your clients."
[4]2019 HealthPocket Info Poll.
[5]2019 Mars Petcare "Better Cities for Pet" Annual Report.
[6]2019 Benefits Pro "Americans willing to spend as much on pets' healthcare as their own."
[7]With deductible savings, your pet's deductible automatically decreases by $25 each policy year that you don't receive a claim reimbursement.
[8]80% of claims are processed within 10 days or less.
[9]This discount is not available in Tennessee. This discount is only available for individuals who access the policy through a group (10% for Groups > 1,000 lives and 5% for Groups 50-999 lives).
© 2020 MetLife Services and Solutions, LLC   L0920008112[exp0921][All States][DC,GU,MP,PR,VI]

Pet Insurance

Pays a portion or full cost of veterinary treatment of an ill or injured pet.

Protect Your Furry Family Members with Pet Insurance offered by MetLife[1].

Pet Insurance Underwritten by Independence American Insurance Company

Now more than ever, pets are playing a significant role in our lives and it is important to keep them safe and healthy. **Help make sure your furry family members are protected** in case of an accident or illness with Pet Insurance offered by MetLife[1].

Why is pet insurance important?

- A small monthly payment can help you prepare for unexpected vet expenses down the road
- More than **6 in 10** pet owners said their pet has had an **emergency medical expense**[2]
- 24% of **pet parents have credit card or personal loan debt** to cover pet health and vet costs[3]
- Average annual cost for a routine vet visit is **$212 for a dog** and **$160 for a cat**; and average annual cost for a surgical vet visit is **$426 for a dog** and **$214 for a cat**[4]
- Pet insurance may not cover pre-existing conditions

...so don't wait!

What covered[5]?

> accidental injuries
> illnesses
> exam fees
> surgeries
> medications
> ultrasounds
> hospital stays
> x-rays and other diagnostics
> diagnostic tests

And our coverage also includes

> hip dysplasia
> hereditary conditions
> congenital conditions
> chronic conditions
> alternative therapies
> and much more!

To get a quote or enroll, call 1-800-GETMET8 **and provide** discount code 4500.

MetLife

EMPLOYEE ASSISTANCE PROGRAM—EAP

We provide you and the members of your household access to the Employee Assistance Program (EAP) at no cost to you.

EAP can help with a wide range of issues, including:

- Up to 5 sessions with a licensed clinician per issue, per individual, per calendar year. You choose between in-person sessions with a provider from LifeWorks' extensive network or convenient and easy telephonic consultations with a licensed LifeWorks clinician. Call 888-319-7819 anytime to speak with a clinician, request a referral, or schedule an appointment.
- Legal Services: Consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, estate planning and more.
- Financial Services: Budgeting, credit and financial guidance (investment advice, loans and bill payments not included), retirement planning and assistance with tax issues.
- Childcare and Eldercare Assistance: Consultation plus referrals to childcare and eldercare providers.
- Identity Theft Recovery Services: Information on ID theft prevention, plus an ID theft emergency response kit and help from a fraud resolution specialist if you are victimized.
- Daily Living Services: Referrals to consultants and business that can help with event planning, transportation services, pet services and more (does not cover the cost nor guarantee delivery of vendors' services).
- Online Member Services: LifeWorks' EAP website and app features a wide range of tools and information to help you take charge of your well-being and simplify your life. Log on to metlifeeap.lifeworks.com using the username and password below to get started.

Call toll-free 888-319-7819 or visit the website at metlifeeap.lifeworks.com
username - metlifeeap / password - eap

FLEXIBLE SPENDING PLAN / DEPENDENT CARE REIMBURSEMENT

Flexible Spending Accounts allow you to pay for goods and services you already use with money deducted from your paycheck before it is taxed.

ASI's Flexible Spending Account plan year is from July 1st through June 30th. However you do have an option to roll over up to $570 of unused funds to the next plan year. Plan carefully when determining how much to contribute as anything over $570 left in the account at the end of the plan year will be forfeited.

Additionally, expenses incurred by domestic partners and their children do not qualify as eligible expenses per Internal Revenue Code 125.

Sample Health Care Expenses

- Acupuncture/Chiropractic
- Alcoholism treatment
- Ambulance
- Deductibles and copays
- Dental/Orthodontia
- Eye Exams
- Hearing exams and hearing aids
- Home health care
- Hospital bills
- Insulin
- LASIK surgery
- Obstetrics and fertility
- Psychiatric care
- Prescription drugs
- Smoking cessation programs if prescribed by your doctor
- X-rays and MRI
- Menstrual care products
- Certain over-the-counter medications

Sample Dependent Care Expenses

- After school care
- Au pair
- Care for children under age 13
- Elder care
- Extended day programs
- Nanny fees
- Nursery school
- Preschool for under 5 year olds
- Sick-child center
- Summer day camp

Expenses for day care, summer camps, etc. cannot be submitted until after services have been received.

Health Care FSA — up to $2,850 annually

This allows you to pay for qualifying out-of-pocket health care expenses for you and your dependents. The amount you choose to contribute will be deducted from your pay in equal installments throughout the year. You cannot change this amount unless you have a qualifying event.

Dependent Care FSA— Up to $5,000 July 1, 2022—June 30, 2023

Eligible expenses are those you must pay for dependent daycare so that you can work. If you are married, your spouse must also work full-time, be actively seeking employment or attending school full-time. If your spouse also contributes to a Dependent Care FSA, your total contributions as a couple cannot exceed the maximum allowed.

FULL-TIME MONTHLY PAYROLL DEDUCTIONS—40 HOURS

Contributions for employees working 40 hours or more per week	Total Premium per Month	Employer Monthly Contribution	Employee Monthly Contribution	Employee Per Pay Period Contribution
Kaiser Permanente HMO				
Employee Only	$598.03	$598.03	$0.00	**$0.00**
Employee + 1 Dependent	$1,196.05	$1,076.45	$119.60	**$59.80**
Employee + 2 or more dependents	$1,692.41	$1,523.17	$169.24	**$84.62**
Sutter Health Plus HMO				
Employee Only	$649.80	$649.80	$0.00	**$0.00**
Employee + 1 Dependent	$1,299.90	$1,169.91	$129.99	**$65.00**
Employee + 2 or more dependents	$1,838.40	$1,654.56	$183.84	**$91.92**
MetLife Dental				
Employee Only	$52.14	$52.14	$0.00	**$0.00**
Employee + Spouse	$103.96	$93.56	$10.40	**$5.20**
Employee + Child(ren)	$116.27	$104.64	$11.63	**$5.82**
Employee + Family	$179.98	$161.98	$18.00	**$9.00**
MetLife Vision -Voluntary				
Employee Only	$9.83	$0.00	$9.83	**$4.92**
Employee + Spouse	$19.07	$0.00	$19.07	**$9.54**
Employee + Child(ren)	$16.68	$0.00	$16.68	**$8.34**
Employee + Family	$27.50	$0.00	$27.50	**$13.75**
MetLaw Legal Plan - Voluntary				
Employee Only or with Family	$19.50	$0.00	$19.50	**$9.75**
MetLife Supplemental Life/AD&D-Voluntary				
Rates depend on age — Please see MetLife documents for rates				

Section 125

Any contributions you make for you and your IRS dependents' medical, dental, and vision plan coverage is automatically deducted from your paycheck on a pretax basis per IRS guidelines under Section 125. This decreases your taxable earnings and can increase your take-home pay.

Your elections remain in effect and can not be changed for 12 months or the remainder of the group plan year, whichever occurs first, unless you have a qualifying life event as defined by the IRS. Qualifying life events are listed in the Employee Benefits Guide.

Imputed Income

If your domestic partner qualifies as your tax dependent for group health plan purposes, the value of your domestic partner's health coverage will not be treated as income and will not be reported on your Form W-2. We are required to "impute" the value of these benefits and report that value as taxable income to the employee. Any contributions made by you towards your domestic partner's coverage can be made on a pre-tax basis through our Section 125 cafeteria plan. In addition, unreimbursed health expenses incurred by your domestic partner may be claimed for reimbursement under a health FSA. If you enroll your domestic partner, you will be required to complete and sign a Certification of Domestic Partner Tax Status annually.

PART-TIME MONTHLY PAYROLL DEDUCTIONS—30 HOURS

Contributions for employees working 30 –39 hours per week	Total Premium per Month	Employer Monthly Contribution	Employee Monthly Contribution	Employee Per Pay Period Contribution
Kaiser Permanente HMO				
Employee Only	$598.03	$448.52	$149.51	**$74.76**
Employee + 1 Dependent	$1,196.05	$598.03	$598.02	**$299.01**
Employee + 2 or more dependents	$1,692.41	$846.21	$846.20	**$423.10**
Sutter Health Plus HMO				
Employee Only	$649.80	$487.35	$162.45	**$81.23**
Employee + 1 Dependent	$1,299.90	$649.95	$649.95	**$324.98**
Employee + 2 or more dependents	$1,838.40	$919.20	$919.20	**$459.60**
MetLife Dental				
Employee Only	$52.14	$26.07	$26.07	**$13.04**
Employee + Spouse	$103.96	$51.98	$51.98	**$25.99**
Employee + Child(ren)	$116.27	$58.14	$58.13	**$29.07**
Employee + Family	$179.98	$89.99	$89.99	**$45.00**
MetLife Vision -Voluntary				
Employee Only	$9.83	$0.00	$9.83	**$4.92**
Employee + Spouse	$19.07	$0.00	$19.07	**$9.54**
Employee + Child(ren)	$16.68	$0.00	$16.68	**$8.34**
Employee + Family	$27.50	$0.00	$27.50	**$13.75**
MetLaw Legal Plan - Voluntary				
Employee Only or with Family	$19.50	$0.00	$19.50	**$9.75**
MetLife Supplemental Life/AD&D-Voluntary				
Rates depend on age — Please see MetLife documents for rates				

Section 125

Any contributions you make for you and your IRS dependents' medical, dental, and vision plan coverage is automatically deducted from your paycheck on a pretax basis per IRS guidelines under Section 125. This decreases your taxable earnings and can increase your take-home pay.

Your elections remain in effect and can not be changed for 12 months or the remainder of the group plan year, whichever occurs first, unless you have a qualifying life event as defined by the IRS. Qualifying life events are listed in the Employee Benefits Guide.

Imputed Income

If your domestic partner qualifies as your tax dependent for group health plan purposes, the value of your domestic partner's health coverage will not be treated as income and will not be reported on your Form W-2. We are required to "impute" the value of these benefits and report that value as taxable income to the employee. Any contributions made by you towards your domestic partner's coverage can be made on a pre-tax basis through our Section 125 cafeteria plan. In addition, unreimbursed health ex-penses incurred by your domestic partner may be claimed for reimbursement under a health FSA. If you enroll your domestic part-ner, you will be required to complete and sign a Certification of Domestic Partner Tax Status annually.

GLOSSARY OF KEY TERMS

Coinsurance – The member and insurance company share the cost of covered procedures in a specific ratio (e.g., member pays 20% and the insurance company pays 80%). This is primarily used in medical and dental PPO plans. If the plan has a deductible, coinsurance does not apply until it has been met.

Copayment – A specific dollar amount you pay to the provider or pharmacy when receiving services or prescriptions.

Deductible – The amount you must pay before the insurance company begins paying benefits on your behalf. The deductible is generally waived for preventive visits and services that require a copayment, including prescription drugs.

Explanation of Benefits (EOB) – A notice sent to the covered person after a claim for payment has been processed by the insurance company. The form explains the action taken on the claim. This explanation usually indicates the amount paid, the benefits available, reasons for denying payment or the claims appeal process.

Formulary – A list containing the names of certain prescription drugs that a medical plan covers when dispensed to its members who have drug coverage through a participating pharmacy. You can obtain a list of formulary medications covered under your plan by visiting the carrier websites referenced on the "Who to Contact" page.

HMO – With this type of medical or dental plan, all care - except emergency services - must be coordinated through a Primary Care Physician (PCP) and/or medical group. Failure to coordinate care through a PCP may result in loss of benefit and greatly increase the amount of money that the member will have to pay for care. Each family member can have a different PCP and they can be changed upon request.

Imputed Income – The IRS has ruled that a domestic partner is not a legal spouse for tax purposes. Employers are obligated to report and withhold taxes on the value of benefits provided to a domestic partner and the domestic partner's children. The applicable amount is treated as taxable income to the employee and added back into an employee's paycheck as taxable income. Imputed income also applies to the premiums an employer pays on your behalf for life insurance coverage amounts in excess of $50,000 and any tax-free LTD benefits. This premium is added to your gross income for tax purposes.

In-Network – All medical, dental and vision carriers have a designated network of doctors or dentists. These providers have agreed to discounted fees with the insurance carrier. In turn, you generally pay a lower percentage of the costs, resulting in less out-of-pocket cost.

Mail Order Prescriptions – A benefit that allows you to order certain maintenance drugs at a reduced cost. You receive multiple months' worth of medication by mail.

Non-formulary – A drug or medication not included on the formulary list of the health insurance plan. If covered, these medications have a higher copay or cost to the member.

Out-of-Network – Medical, dental and vision providers who do not agree to accept the negotiated rates offered by insurance companies. A member may pay higher copays and/or deductibles to see an out-of-network provider or have no coverage at all.

Out-of-Pocket Maximum - Generally, the maximum amount of money a member will have to pay each year. The out-of-pocket maximum most often applies to coinsurance. An individual who meets the out-of-pocket maximum may still be responsible for copays.

PCP – Primary Care Physician. A doctor who is your first point of contact and who must coordinate your care and refer you to specialists. Primarily required by medical or dental HMO plans.

Preferred Provider Organization (PPO) – A type of medical or dental plan that gives members the flexibility to see any provider. If a member chooses an in-network provider or hospital, they will typically have to pay less out-of-pocket.

Pre-determination of Benefits – An estimate reflecting the amount of money an insurance company intends to pay on a member's behalf for a particular procedure. This generally applies to medical and dental plans.

Reasonable and Customary – The range of usual fees for comparable services charged by professionals in a geographic area. If your provider charges more than the reasonable and customary fee, you may be responsible for paying the difference. This is often referred to as "Balance Billing".

2022-2023 ANNUAL NOTICES

IMPORTANT

Please be sure to read each of the notices on the following pages. If you have any questions or would like to obtain additional information, please contact Human Resources.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights Act

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 the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Kaiser Permanente (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)
Plan 2: Sutter Health Plus (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

If you would like more information on WHCRA benefits, please call Myra Makelim at 916-278-5484 or makelim@csus.edu.

2022-2023 ANNUAL NOTICES

Patient Protections Disclosure

The Associated Students, Inc. Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente and Sutter Health Plus designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at 800-464-4000 or www.kp.org and Sutter Health Plus at 855-315-5800 or www.sutterhealthplus.org.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser Permanente and Sutter Health Plus or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at 800-464-4000 or www.kp.org or Sutter Health Plus at 855-315-5800 or www.sutterhealthplus.org.

2022-2023 ANNUAL NOTICES

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Associated Students, Inc. is committed to the privacy of your health information. The administrators of the Associated Students, Inc. Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure. The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Myra Makelim – HR Director at 916-278-5484 or makelim@csus.edu.

HIPAA Special Enrollment Rights

Associated Students, Inc. Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Associated Students, Inc. Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Myra Makelim – HR Director at 916-278-5484 or makelim@csus.edu.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

2022-2023 ANNUAL NOTICES

Notice of Creditable Coverage

Important Notice from Associated Students, Inc.

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 Associated Students, Inc. 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.

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. **Associated Students, Inc. has determined that the prescription drug coverage offered by the medical plan 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.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare 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 Associated Students, Inc. coverage will not be affected. You can keep this coverage if you elect part D.

If you do decide to join a Medicare drug plan and drop your current Associated Students, Inc., 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 Associated Students, Inc. 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 October 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 Associated Students, Inc. 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:	**July 01, 2022**
Name of Entity/Sender:	**Associated Students, Inc.**
Contact—Position/Office:	**Myra Makelim – HR Director**
Office Address:	**6000 J Street Sacramento, California 95819-6011 United States**
Phone Number:	**916-278-5484**

2022-2023 ANNUAL NOTICES

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

2022-2023 ANNUAL NOTICES

ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MAINE – Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA – Medicaid and CHIP (Hawki)	**MINNESOTA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS – Medicaid	**MISSOURI – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY – Medicaid	**MONTANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA – Medicaid	**NEBRASKA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

2022-2023 ANNUAL NOTICES

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	**VERMONT– Medicaid**
Website: https://medicaid.ncdhhs.gov/ 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	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND – Medicaid and CHIP	**WYOMING – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Myra Makelim.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td colspan="2">3. Employer name
Associated Students, Inc.</td><td colspan="2">4. Employer Identification Number (EIN)
94-1347023</td></tr>
<tr><td colspan="2">5. Employer address
6000 J Street</td><td colspan="2">6. Employer phone number
916-278-5484</td></tr>
<tr><td colspan="2">7. City
Sacramento</td><td>8. State
California</td><td>9. ZIP code
95819-6011</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job?
Myra Makelim</td></tr>
<tr><td>11. Phone number (if different from above)</td><td colspan="3">12. Email address
makelim@csus.edu</td></tr>
</table>

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

2022-2023 ANNUAL NOTICES

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

□ All employees. Eligible employees are:

X Some employees. Eligible employees are:
Full Time employees working 30 or more hours

- With respect to dependents:

X We do offer coverage. Eligible dependents are:
Same and opposite sex Spouse
Same sex Domestic Partner (registered with the State)
Dependent Children up to age 26 for medical coverage

□ We do not offer coverage.

X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

NOTES

This benefit summary prepared by

Insurance | Risk Management | Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.