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. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

This benefit summary prepared

Arthur J. Gallagher
BUSINESS WITHOUT BARRIERS™

Benefit Guide 2017–2018

Helping you make informed choices about your employee benefits.

Associated Students, Inc.

About this Guide

We consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to our company, we are committed to providing you with a competitive benefits program as part of your total compensation.

This guide has been prepared to assist you in making informed decisions regarding your employee benefits. We urge you to read this guide carefully and keep it as a reference.

Great care has been taken to ensure that 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.

Eligibility for Benefits

Full-time employees will become eligible for benefits first of the month following your full time hire. 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

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

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

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

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

Individual Mandate: Make Sure You're Covered

Starting January 1, 2014, the Affordable Care Act — also known as "healthcare reform" — requires you and your dependents to have health insurance in 2014 (unless you meet certain exceptions). You can meet this requirement by enrolling in a ASI Inc.'s plan, purchasing coverage in the Marketplace Exchange or if you have Medicare or Medi-Cal. If you do not have health insurance in 2017, you may pay a tax penalty when you file your taxes at the end of the year.

ASI, 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 Marketplace because you have access to an employer plan that complies with the affordability standard.

MONTANA – Medicaid	OREGON – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	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
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

Making Changes to Your Benefits

During Open Enrollment you can change your benefit choices. Open Enrollment is in June with changes being 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 birth, adoption or marriage
- 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.**

Medical Plan Options: Kaiser Permanente

We offer employees a choice of medical plans through Western Health Advantage (WHA) and Kaiser. 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. The information listed is only a brief summary. For complete details refer to the carrier plan documents.

Medical Plan Options	Kaiser
Deductible	None
Annual Out-of-Pocket Maximum	$1,500 Ind. / $3,000 Family
Preventive Care Services	
Annual physical exam and well baby	Covered in Full
Maternity care, after the initial diagnosis	Covered in Full
Professional & Outpatient Services	
Office visits	$20 Copay
Eye and hearing examinations	Covered in Full
Outpatient surgery	$20 Copay
Lab, X-ray, MRI, CT and Pet Scans	No Charge
Hospitalization Services	
Hospital inpatient services	No Charge
Behavioral Health Services	
Outpatient mental health	$20 Copay
Inpatient mental health	No Charge
Inpatient substance abuse (detox only)	No Charge
Other Services	
Emergency room	$50 Copay
Vision materials	$175 allowance every 24 mo
Chiropractic (30 visits/yr)	$15 Copay
Prescriptions Supply	
Generic Plan Pharmacy (30 day supply) Generic Mail Order (100 day supply)	$10 Copay $20 Copay
Brand Plan Pharmacy (30 day supply) Brand Mail Order (100 day supply)	$20 Copay $40 Copay

COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dash/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

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

If you and 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 Sate 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, 2017. Contact your State for more information on eligibility—

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-54471	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	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

Medical Plan Options: Western Health Advantage (WHA)

We offer employees a choice of medical plans through Western Health Advantage (WHA) and Kaiser. This page provides information on the Western Health Advantage (WHA) plan.

As a member of WHA, 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. For complete details refer to the carrier plan documents.

Medical Plan Options	Western Health Advantage
Deductible	None
Annual Out-of-Pocket Maximum	$1,500 Ind. / $2,500 Family
Preventive Care Services	
Annual physical exam and well baby	Covered in Full
Maternity care, after the initial diagnosis	Covered in Full
Professional & Outpatient Services	
Office visits	$20 copay
Eye and hearing examinations	$20 copay
Outpatient surgery	$100 copay
Laboratory and X-ray	Covered in Full
Hospitalization Services	
Hospital inpatient services	No Charge
Behavioral Health Services	
Outpatient mental health	$20 copay
Inpatient mental health	No Charge
Inpatient substance abuse (detox only)	No Charge
Other Services	
Emergency room	$100 copay
Urgent care center	$35 copay
Vision Coverage	$100 allowance every 24 months
Chiropractic or Acupuncture (20 visits/yr)	$15 copay
Prescription Drug Plan	**Retail Pharmacy (30 day) Mail Order (100 day)**
Tier 1 - Preferred Generic medication	$10 Copay / $25 Copay
Tier 2 - Preferred brand name medication	$30 Copay / $75 Copay
Tier 3- Non-Preferred medication	$50 Copay / $125 Copay

Dental

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.

Humana offers you 2 levels of dental providers:
Contracted Providers (In Network) & Non-Contracted (OON) providers.

When you visit a dentist who participates in the Humana Dental PPO Network, you can save an average of up to 30 percent. Plus, the PPO network is nationwide so you can find a participating dentist near your home or work, when you're on vacation or away at college.

Example: A member needs to seek dental service and has a Humana Dental PPO plan that pays 80 percent to both a contracted and non-contracted dentist, however you will have more out of pocket costs when services are performed by a non-contracted provider. The chart below shows what a member will save by visiting an In Network provider dentist.

Sample scenario

The scenario below reflects charges for a crown that are paid at 50%. 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	Humana Contracted In-Network Dentist	Out of Network Non-Contracted Dentist
Dentist's charge for a crown	$1,000	$1,000
Sample plan allowance Based on:	$640 PPO plan allowance	$700 Plan allowance
Coinsurance amount	50%	50%
Plan payment	$320	$350
Balance billing	No	Yes: $300
Enrollee payment	($640 x 50%) = $320	($700 x 50%) + $300 (difference between allowed and actual charges) = $650

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependent experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependents become eligible for premium assistance under an option state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

To be eligible for the two above listed special enrollment opportunities you must request coverage **within 60 days** after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain additional information, please contact Human Resources.

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)**.

HIPAA Protecting Your Health Information Privacy Rights

Your employer is committed to the privacy of your health information. The administrators of your Group 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 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 the Plan carrier directly.

HIPAA Special Enrollment Rights

Loss of Other Coverage — If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependents' other coverage. To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after you or your dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person (s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

New dependent as result of 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 dependents. To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after the marriage, birth, adoption, or placement for adoption.

Dental

How to find a participating provider

Go to Humana.com anytime and select " Find a healthcare provider." We update the list of participating dentist's daily. You can also call 1-800-233-4013. A Humana customer care specialist will be happy to help you from 8 am—6 pm, Monday—Friday.

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.

HUMANA		
Network	**In Network**	**Out of Network Provider**
Class I—Diagnostic/Preventative Routine Oral Exams Bitewing X-Rays Routine Cleanings Fluoride Treatments (children) **Smile Rewards**	100%	100%
Class II—Basic Services Sealants Consultations Palliative treatment Fillings Simple and Surgical Extractions Endodontics Periodontal Maintenance & Surgery	90%	80%
Class III—Major Services Bridges Full and Partial Dentures Crowns, Inlays, Onlays	60%	50%
Individual Deductible Family Deductible	$25 $75	$50 $150
Benefit Year Maximum	Unlimited	Unlimited
Class IV Orthodontia (Adults & Children)	50%	50%
Lifetime Orthodontia Max	$2,000	$2,000

Voluntary Vision

We offer employees a voluntary vision plan through Medical Eye Services (MES). With this plan, you can receive care from any provider, however you will receive a higher level of benefit if you stay in-network. Network providers have contracts with carriers that provide discounts for their services so obtaining services from a MES provider will maximize your benefits.

Out-of-network providers will bill you directly and you will need to submit your claim to MES for reimbursement up to the allowed amount. In these cases, you are responsible for any amount in excess of the reimbursement level.

Medical Eye Services (MES)		
Exam Copayment Material Copay Contact Lens Fitting	$10 $0 Not Covered	
FREQUENCY	Exam Lenses Contact Lenses* Frame	Every 12 months Every 12 months Every 12 months Every 24 months
	IN-NETWORK	**OUT-OF-NETWORK**
EYE EXAM Ophthalmologist Optometrist	 $10 Copay $10 Copay	 Reimbursed up to $40 Reimbursed up to $40
Single Lenses Bifocal Lenses Trifocal Lenses Lenticular	Covered Covered Covered Covered	Reimbursed up to $40 Reimbursed up to $60 Reimbursed up to $80 Reimbursed up to $125
FRAME	$130 retail allowance	Reimbursed up to $78
CONTACT LENSES Medically Necessary Cosmetic	 Covered with authorization $130 retail allowance	 Reimbursed up to $210 Retail Reimbursed up to $117 Retail

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 ASI, 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…
For further information please contact human resources (listed below). 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 ASI, 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).

Date: May 12, 2017
Name of Entity/Sender: Associated Students, Inc.
Contact--Position/Office: Gennifer Lundahl-Gonzales
Address: 6000 J Street, Sacramento, CA 95819
Phone Number: 916-278-5484

Important Notice from ASI, Inc. About Your Prescription Drug Coverage and Medicare

Medicare Part D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ASI, 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. The Carrier's have determined that the prescription drug coverage with the Kaiser HMO, and WHA HMO plans offered are, 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 ASI, 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 ASI, Inc. coverage, be aware that you and your dependents may be able to get this coverage back.

Life, AD&D and Long Term Disability

Mutual of Omaha—Group Life Insurance/AD&D (Full Time Employees Only)	
Benefit Amount	$50,000
Accelerated Death Benefit	50% of policy
Reduction Schedule	At age 70—reduces to 65% At age 75—reduces to 50%

Mutual of Omaha—Voluntary Life (Full Time Employees Only)	
Employee Benefit Amount Guaranteed Issue	Up to 5 times annual salary to a max of $300,000 $50,000
Spouse Benefit Amount Guaranteed Issue	50% of Employee benefit $25,000
Child Benefit Amount	$10,000

Mutual of Omaha—Long Term Disability (Full Time Employees Only)	
Percentage of Monthly Earnings	66.67%
Maximum Monthly Benefit	$3,000
Elimination Period	90 Days

403(b) Retirement Plan	
Waiting Period for Part time employees **Employee** Contributions	Employees must work 1,000 hours per year
Waiting Period for Full time employees **Employee** Contributions	None
Waiting Period for Part time & Full time **Employer** Contributions	Two years of service working 1,000 hours per year
Employer Contributions	Associated Students, Inc. contributes 10% of gross wages per employee Employees do not need to contribute to receive employer contributions

Flexible Spending Account/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, Inc.'s Flexible Spending Account plan year is from July 1st through June 30th. Plan carefully when determining how much to contribute. The IRS has imposed a "use it or lose it " rule and any amount remaining in your health care or dependent care accounts at the end of the plan year will be forfeited, as required by law. However you have a grace period until September 15th to utilize your FSA account and until September 30th to submit claims.

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
- Laboratory fees
- LASIK surgery
- Mileage incurred going to and from medical appointments
- Obstetrics and fertility
- Psychiatric care
- Prescription drugs
- Smoking cessation programs if prescribed by your doctor
- X-rays and MRI

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 years olds
- Sick-child center
- Summer day camp
- Care for an adult dependent in an adult day care center

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

Health Care FSA limit - $2,000

This account allows you to pay for qualified 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 limit- $5,000**

Eligible expenses are 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 $5000.

2017 Annual Notices

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires your employer to notify you, as a participant or beneficiary of the Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician 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.
- prosthesis and treatment of physical complications of the mastectomy, including lymph edema.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description.

2017 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.

The Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery to less than 48 hours, and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

- deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage.
- provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage.
- provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay.
- require a mother to give birth in a hospital.
- restrict benefit for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description.

FULL-TIME EMPLOYEES

Per Pay Period Contributions

(31-40 hours per week)

Western Health Advantage (24 pay periods)

Rates	18-29	30-39	40-49	50-54	55-59	60-64	65+
Employee Only	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Employee and Spouse	$30.81	$35.65	$42.38	$52.67	$61.90	$75.68	$76.74
Employee and Children	$35.29	$38.31	$39.99	$46.83	$52.82	$61.99	$61.79
Employee and Family	$52.16	$60.19	$64.54	$71.48	$78.34	$92.43	$92.46

Kaiser (24 pay periods)

	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
Employee Contribution	$0.00	$25.83	$36.55

Humana Dental (24 pay periods)

Employee Contribution	
Employee Only	$0.00
Employee + 1 dependent	$0.00
Employee + Child or Children	$0.00
Employee + Family	$0.00

MES Vision (24 pay periods)

Employee Contribution	
Employee Only	$5.73
Employee + Spouse	$10.32
Employee + Ren)	$10.89
Employee + Family	$14.90

Mutual of Omaha

	Basic Life and AD&D	Long Term Disability
Employee Cost	100% Paid by Associated Students, Inc.	

PART– TIME EMPLOYEES
Per Pay Period Contributions
(21-30 hours per week)

Western Health Advantage (24 pay periods)

Rates	18-29	30-39	40-49	50-54	55-59	60-64	65+
Employee Only	$145.39	$165.41	$195.16	$263.56	$318.37	$386.44	$385.06
Employee + Spouse	$308.09	$356.49	$423.84	$526.71	$618.96	$756.80	$767.42
Employee + Child(ren)	$352.85	$383.10	$399.85	$468.28	$528.17	$619.90	$617.85
Employee + Family	$521.57	$601.86	$645.37	$714.84	$783.36	$924.28	$924.63

Kaiser (24 pay periods)

	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
Employee Contribution	$129.13	$258.26	$365.44

Humana Dental (24 pay periods)

Employee Contribution	
Employee Only	$11.28
Employee + Spouse	$22.55
Employee + Child or Children	$31.80
Employee + Family	$43.89

MES Vision (24 pay periods)

Employee Contribution	
Employee Only	$5.73
Employee + Spouse	$10.32
Employee + Ren)	$10.89
Employee + Family	$14.90

Plan and 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 NAME	MEMBER SERVICES/WEBSITE	GROUP NO.
MEDICAL		
Kaiser Kaiser Chiropractic (ASH)	800-464-4000 / www.kp.org 800-678-9133 Call for provider list	1468
Western Health Advantage	916-563-2250 www.westernhealth.com	102891
DENTAL		
Humana Dental	800-233-4013 www.humana.com	TBD
VISION		
Medical Eye Services	800-877-6372 www.mesvision.com	29113
LIFE/DISABILITY		
Mutual of Omaha	800-775-8805 www.mutualofomaha.com	G00094Y7
FSA/DEP. CARE ADMINISTRATION		
Employee Benefit Specialist	888-327-2770 www.ebsbenefits.com	N/A
403(b) RETIREMENT PLAN		
Principal Financial Group	559-733-1670 www.principal.com	N/A
BENEFIT & CLAIM QUESTIONS		
Gallagher Benefit Services Christine Colyer	916-431-2509 916-431-2519 fax	**christine_colyer@ajg.com**