2018 WELLNESS AND BENEFITS GUIDE

California College of the Arts

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Welcome and Plan Enhancements

Esteemed Colleagues,

At California College of the Arts (CCA) we work hard to maintain affordable and comprehensive benefit options to help care for our employees and their families. This guide provides an overview of your benefits and the information you will need to make the choices that are right for you for the 2018 benefits plan year.

Please take note of the following improvements, effective January 1, 2018 including:

- The addition of a more affordable HMO Trio option through Blue Shield.
- Continued employer contributions into Health Savings Accounts for the High Deductible Health Plan.
- Prudential will replace Anthem Blue Cross Life and Disability Insurance.

During Open Enrollment, you'll have the opportunity to make changes to your benefit plans in Workday. The enrollment decisions you make will remain in effect from January 1, 2018 through December 31, 2018. Keeping your same benefits coverage is easy! No action is required to keep your current benefits elections for the 2018 plan year, except for medical and dependent care flexible spending accounts — which must be renewed every year.

It's important that you learn about the coverage options available to you, compare the features and costs, and decide which options are best for your individual situation and budget. So please take the time to attend a benefits information session and read all of your benefits materials carefully.

Questions? Please do not hesitate to reach out to the CCA Benefits Support Center at **benefits@cca.edu**.

Thanks for all you do!

Warmly,

Leslie Gray
Vice President, Human Resources

Eligibility

Staff: You're eligible for benefits if you are a regular staff employee working 30 or more hours per week.

Ranked Faculty: You're eligible for benefits if you possess an annual teaching contract for three or more lines per academic year.

Unranked Faculty: Per the terms of the Collective Bargaining Agreement, you're eligible for benefits if you have accepted a one or two year appointment for three or more lines per academic year.

Your benefits are effective on the first day of the month following your benefit event date. If your benefit event begins on the first day of the month, then your benefits coverage is effective on that day.

You may also enroll your eligible dependents for benefits coverage. Your cost for dependent coverage will vary depending on the number of dependents you cover and the particular plan you choose. When enrolling dependents, you must select the same plans for your dependents as you select for yourself. Eligible dependents include:

- Your legal spouse or qualified domestic partner*
- Children under the age of 26, regardless of student, dependency, or marital status
- Children who are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return, may continue coverage past age 26

It is important you complete the enrollment process within 30 days of your benefit event date. You may not enroll in benefits until the next Open Enrollment period, plus you may be restricted from some benefits coverage.

DOMESTIC PARTNER COVERAGE

To qualify for Domestic Partnership coverage, both individuals must meet the specific criteria below:

- At least 18 years of age and mentally competent to consent to a contract.
- Not married to or legally separated from anyone else.
- Not related by blood to a degree of closeness that would prohibit legal marriage in a state in which they reside.
- Have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations which has existed for at least six months prior to the enrollment of the Domestic Partner for coverage(s) and which is expected to last indefinitely.
- Have shared the same residence on a continuous basis for at least 12 months immediately prior to the enrollment of the Domestic Partner coverage.

* The IRS requires that any portion of the premium an employer funds to cover a domestic partner and/or a domestic partner's dependent child(ren) be included in the employee's gross income for the calculation of federal income taxes and FICA employment taxes. Additionally, any portion of the premium an employee pays for a domestic partner and/or a domestic partner's child(ren) must be paid for with post-tax dollars.

TERMINATION OF COVERAGE

Should your employment with CCA end, your medical, dental and vision coverage will continue until the last day of the month of your separation date. This is also true if you continue to be employed by CCA, no longer maintain a benefits eligible position.

You may continue health care benefit coverage for a limited period of time under federal and state COBRA regulations by paying the cost of the premiums directly to our third party COBRA administrator. Benefit coverage in the Life, Disability, and Flexible Spending Account plans will end on the last day of your employment.

Qualified Life Events

Once you elect your benefit options, they remain in effect for the remainder of the plan year. Outside of the College's Open Enrollment periods, you may only change coverage during the plan year if you have a Qualified Life Event, and you must do so within 30 days of the event. Qualified Life Events include:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse, domestic partner or dependent child
- Adoption of or placement for adoption of your child
- Change of employment status by you or your spouse
- A significant change in your or your spouse's health coverage due to your spouse's employment
- Qualification by the plan administrator of a Medical Child Support Order

If you have a Qualified Life Event and want to request a mid-year change, you must initiate the benefit change in Workday. You may add or drop dependents from your coverage as long as the changes are consistent with your Qualified Life Event. Be prepared to provide documentation to support the Qualified Life Event. After submitting your elections through Workday, you will be notified about the status of your benefit change request. Please contact **benefits@cca.edu** with any questions.

Medical Plans

Medical coverage offers health care protection for you and your family. CCA offers you a choice of five medical plans, that fall into one of the three categories below. Be sure to read about each plan so you can select the plan that best meets the needs of you and your family.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Blue Shield PPO option offers the freedom to see any provider when you need care. You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs. In-network providers charge members reduced, contracted fees instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits, which is commonly referred to as balance billing.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Similar to the PPO, you have the option to choose any provider when you need care. In addition with the Blue Shield HDHP, you're automatically enrolled in a Health Savings Account (HSA) funded in part by CCA. The higher deductible in the HDHP applies to almost all health care expenses including those for prescription drugs. The HSA helps to offset that cost with funds that you can use toward medical expenses. Once your deductible has been met, you will continue to pay a prescription copay until your out-of-pocket maximum is met, and then the plan pays 100% of the cost of any additional medical expenses.

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

These plans are designed for you to visit providers that are only contracted with a specific carrier. Your HMO plan choices are the Kaiser Permanente HMO, the Blue Shield HMO, and a new, lower cost option, the Blue Shield Accountable Care Organization (ACO) Trio HMO. The Trio ACO HMO offers the same benefits as the other Blue Shield HMO plan but the access to the networks of providers are different. With the HMO Plans, you will need to annually confirm your current or select a new Primary Care Physician directly with the HMO provider. Specialist care is coordinated through the Primary Care Physician. Note that services received outside the network are not covered except for emergency services.

MEDICAL PLAN COMPARISON

	Blue Shield HDHP (HSA)		Kaiser Permanente HMO	Blue Shield HMO	Blue Shield HMO Trio	Blue Shield PPO	
	IN-NETWORK ONLY	OUT-OF-NETWORK	IN-NETWORK ONLY	ACCESS+ HMO NETWORK ONLY	TRIO ACO HMO NETWORK ONLY	IN-NETWORK ONLY	OUT-OF-NETWORK
Calendar Year Deductible							
Individual	$2,700	$3,500	$0	$0	$0	$500	
Family	$5,200	$7,000	$0	$0	$0	$1,000	
Calendar Year Out-of-Pocket Maximum (includes Deductible)							
Individual	$3,000	$7,000	$1,500	$1,000	$1,000	$2,200	$5,200
Family	$6,000	$14,000	$3,000	$2,000	$2,000	$4,400	$10,400
Lifetime Maximum	Unlimited		Unlimited	Unlimited	Unlimited	Unlimited	
	You Pay		**You Pay**	**You Pay**	**You Pay**	**You Pay**	
Coinsurance / Copays							
Preventive Care	$0	40%*	$0	$0	$0	$0	30%*
Primary Care Physician/ Specialist	20%*	40%*	$20	$10	$10	$20	30%*
Telemedicine	$5	N/A	N/A	$5	$5	$5	N/A
Diagnostics, X-ray and Lab	20%*	40%*	$10 for most X-rays; $50 for MRI, most CT and PET scans	$0	$0	$20, or $45 if performed at an outpatient hospital facility	30%*
Urgent Care	20%*	40%*	$20	$10	$10	$20	30%*
Emergency Room	20%*	20%*	$50, waived if admitted	$100, waived if admitted	$100, waived if admitted	$100, waived if admitted, then 10%	$100, waived if admitted, then 10%
Inpatient Hospital Care	20%*	40%* up to $1,000 per day	$250	$100	$100	$100 + 10%*	30% up to $600 per day
Outpatient Surgery							
• Free-Standing Surgery Center	20%*	40%*	$100	$100	$100	10%*	30% up to $350 per day
• Hospital Surgery Center	20%*	40%*		$125	$125	10%*	30% up to $350 per day
Pharmacy	Deductible must be met before Rx copays apply						
Retail RX (up to 30-day supply)							
Generic	$10*	Copays + 25% of allowed amount	$10	$10	$10	$10	Copays + 25% of allowed amount
Brand	$30*		$30	$20	$20	$20	
Non-Formulary	$50*		N/A	$35	$35	$35	
Specialty	30%, $200 maximum	30% + 25% of billed amount, up to $200	$60	20%, $200 maximum	20%, $200 maximum	30%, $200 maximum	30% + 25% of billed amount, up to $200
Self-Injectables	30%, $200 maximum		$30	20%, $200 maximum	20%, $200 maximum		
Mail Order RX (up to 90-day supply) **							
Generic	$10*	N/A	$20	$20	$20	$20	N/A
Brand	$60*		$60	$40	$40	$40	
Non-Formulary	$100*		N/A	$70	$70	$70	
Self-Injectables	N/A		N/A	N/A	N/A	N/A	

* After deductible

** Mail order is 100 days for Kaise

Health Savings Account

The High Deductible Health Plan (HDHP) includes a Health Savings Account (HSA) that CCA automatically makes contributions into. An HSA is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars. Both you and CCA make contributions to your account, and you — not CCA — own and control the account. Contributions are not federally taxed, and you can invest the balance in a variety of options. Your account (including interest and investment earnings) grows tax-free, and as long as the funds are used to pay for qualified medical expenses, they are spent tax-free.

You can use the money in your HSA to pay for qualified medical expenses now or in the future. Your HSA can be used for your expenses and those of your spouse and dependents, even if they are not enrolled in a qualified HDHP. However you can only contribute to an HSA while enrolled in a HDHP.

Unlike a Flexible Spending Account, there is no "use it or lose it" rule—the money in your account will automatically roll over year after year. And since it is an individual account, the balance is yours even if you change health plans or leave CCA.

WHO IS ELIGIBLE TO OPEN AN HSA?

You are eligible to open and fund an HSA if you:

- Are enrolled in an HSA-eligible HDHP.
- Are not covered by other non-high deductible health plans, such as your spouse's health plan, Health Care Flexible Spending Account, or Health Reimbursement Account.
- Are not eligible to be claimed as a dependent on someone else's tax return.
- Are not enrolled in Medicare or TRICARE.
- Have not received Veterans Administration benefits.

YOUR HSA

The HSA is administered by Health Equity. Once you're enrolled in the HSA, you'll receive a debit card from Health Equity for managing your HSA reimbursements. Funds available for reimbursement are limited to the balance in your HSA. To view your account information, go to **www.healthequity.com**.

If you are re-electing the HDHP, your 2017 HSA contributions will roll over for 2018. Changes to HSA contributions may be made via Workday at any time. See chart below for IRS HSA contribution limits.

HSA accounts are portable and yours to keep regardless of your employer or insurance carrier. Therefore, you (not CCA) are responsible for maintaining all records and receipts for HSA reimbursements in the event of an IRS audit.

Through Health Equity, you can set up your HSA to directly pay your providers. Then, pay the provider with your HSA debit card based on the balance due after discount.

Please note: You may open an HSA at any financial institution of your choice. However, payroll deductions and company funding are available only for HSAs through Health Equity.

Don't forget to designate a beneficiary for your HSA account! See page 16, "Designating a Beneficiary" for instructions.

MAXIMUM CONTRIBUTIONS

HSA contributions (yours and CCA contributions combined) may not exceed the annual maximum amount established by the IRS. The annual contribution maximum is based on a combination of CCA's contribution and your elected amount.

	Maximum Allowed Contribution	CCA Contribution*	Your Maximum Contribution
Employee Only	$3,450	$1,500	$1,950
Employee + 1	$6,900	$2,250	$4,650
Family	$6,900	$3,000	$3,900

*Prorated for new hires

Catch-up Contributions: If you are age 55+, you are eligible to contribute an additional $1,000 annually to your HSA account.

A Note for Employees Residing in CA: Subject to state law contributions, earned interest or investment gains related to an HSA bank account are not exempt from state taxes.

HSA Examples

The following sample scenarios are for illustration purposes only.

Lynne Asks: How do HSA and HDHP work together?

- Lynne is single. She is enrolled in the Blue Shield HDHP (HSA) plan, which has a deductible of $2,700.
- The cost of her annual physical exam and other preventive care is 100 percent covered by Blue Shield.
- Lynne takes prescription medication on a regular basis. She is responsible for paying for her prescriptions and other qualified medical care until she has paid $2,700—the amount of her deductible.
- After that, she is responsible for paying 20 percent of the cost—or coinsurance—until she reaches her plan's out-of-pocket limit of $3,000.

EXPENSE	CHARGE	WHAT THE PLAN PAYS	WHAT LYNNE PAYS
Annual physical exam	$500	$350*	$0
Medication	$3,000	$320	$2,700 + $100 (deductible + coinsurance)**
TOTALS	$3,500	$670	$2,800

How the HSA Saved Lynne Money

- She uses pretax payroll deductions, available from her employer, to save $1,950 in her HSA.
- Lynne receives $1,500 from CCA in HSA contributions.
- Her federal tax savings with her HSA are approximately $742.
- Even if she uses the HSA to reimburse herself for all of her out-of-pocket expenses, she has still saved $742 in taxes.
- After that, she is responsible for paying 20 percent of the cost—or coinsurance—until she reaches her plan's out-of-pocket limit of $3,000. Prescription drugs would now be eligible for scheduled copayments.

HSA deposits	**$3,450**
Total out-of-pocket cost (deductible + coinsurance)	$2,800
Account carries forward	$650

* Plan covers preventive care 100%. Plan's negotiated rates with Lynne's physician apply.
** Plan calls for 20% coinsurance once the deductible is met, up to a maximum out-of-pocket expense of $3,000.

Mark Asks: How does funding an HSA save on taxes?

- Mark has family coverage with a High Deductible Health Plan
- Mark receives $3,000 from CCA in HSA contributions
- His total pretax contribution for the year is $6,900
- Every pay period, he puts $144.23 into his HSA
- Mark's federal tax bracket is 28 percent.* Mark lives in a state where HSA contributions are not taxed**
- His total federal and state income tax savings on contributions this year are $6,900 x 0.28 (Federal tax) + $6,900 x 0.03 (State tax) = $2,139

Visit **www.equityhealth.com** for your own information on claims, account balances and more.

* Please see www.IRS.gov to determine your tax bracket.
**Hypothetical example assumes a state tax rate of 3 percent. While Health Savings Accounts were created by the federal government, states can choose to follow the federal tax treatment guidelines or establish their own. Some states, like CA, have chosen to tax HSA contributions. Talk to your financial advisor or consult your state department of revenue for more information.

Telemedicine

KAISER VIDEO VISIT

If you are in the Kaiser HMO plan, you can set up Video Visits with your doctor. When scheduling an appointment with your doctor, simply ask if a video visit is right for your symptoms.

JOIN ON YOUR MOBILE DEVICE

- Go to **kp.org/mydoctor/videovisits**
- Choose **Get the App** to download My Doctor Online. Open the app and log in using your **kp.org** username. If you do not have a kp.org username, tap **Sign In Help** at the bottom and follow the prompts to sign in with your medical record number
- Go to **Appointments**
- Tap on **Join** to start your video visit

JOIN ON YOUR COMPUTER

- Go to **kp.org/mydoctor/videovisits**
- Click **Get Prepared** and follow the instructions for downloading and installing the Video Web plug-in
- Click **Join Your Video Visit** to start your video visit

NEED HELP?

Go to **kp.org/mydoctor/videovisits** and click **Video Visit Support**

BLUE SHIELD OF CALIFORNIA TELADOC

U.S. board-certified doctors are available 24/7 to resolve many of your non-emergency issues through phone or video consults. Use Teladoc if you are considering the ER or Urgent Care for a non-emergency, when you are away from home, or if you need short-term prescription refills.

SET UP ACCOUNT

- Visit **Teladoc.com/bsc**, complete the required information and click on **Set Up Account**. You can also call Teladoc for assistance

PROVIDE MEDICAL HISTORY

- Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis
  - **Web:** Log in to **Teladoc.com/bsc** and click **My Medical History**
  - **Mobile:** Log in to **Teladoc.com** and complete the **My Health Record** section. Visit **Teladoc.com/mobile** to download the app.
  - **Phone:** Teladoc can help you complete your medical history over the phone. Call 800-Teladoc (835-2362).

REQUEST A CONSULT

- Once your account is set up, request a consult any time you need care

See benefits summary chart on page 8 for costs associated with Telemedicine visits for your Blue Shield of California medical plan.

Dental Plans

Dental coverage helps you maintain good dental health. You have a choice of two plans, provided through Anthem BlueCross. Both plans cover preventive care including regular checkups, as well as fillings and other dental procedures. You may visit any dentist you choose, but you'll receive a higher level of benefits when you go to an in-network dentist. Dental premiums are based on the coverage tier you choose.

	Core PPO Plan		Buy-Up PPO Plan	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible				
Individual	$150		$50	
Family	$50 per insured person; maximum of $150 per family		$50 per insured person; maximum of $150 per family	
Calendar Year Out-of-Pocket Maximum				
Per Individual	$1,500 per individual (Basic and Major Services combined)		$2,000 per individual (Basic and Major Services combined)	
	You Pay		**You Pay**	
Services				
Office Visit	$0		$0	
Preventive Care				
Exams, Cleanings, X-rays, Fluoride Treatments	$0	100% of allowed amount	$0	100% of allowed amount
Basic Services				
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	10%	20% of allowed amount	10%	20% of allowed amount
Major Procedures				
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	40%	50% of allowed amount	40%	50% of allowed amount
Orthodontia				
Adults (Buy-up Plan Only)	N/A		50% up to a lifetime maximum benefit of $1,500 per individual; deductible waived	
Children (up to age 19)	50% up to a lifetime maximum benefit of $1,500 per individual; deductible waived			

Vision Plan

Annual vision exams not only help keep your vision healthy, they can identify certain medical conditions such as diabetes or high cholesterol. CCA offers vision coverage through VSP, one of the largest networks of vision care providers. Under the vision plan, you may use the eye care professional of your choice. However, when you use a VSP provider, you will receive higher levels of benefits. To find a VSP network provider, visit **www.vsp.com**.

	Vision Plan	
	VSP PROVIDER NETWORK	NON-VSP PROVIDER
	You Pay	**Reimbursement**
Cost		
Exam	$25	Up to $50
Materials	$25	Up to allowable amount
Covered Services – Lenses		
Single Lenses	$0	Up to $50
Bifocals	$0	Up to $75
Trifocals	$0	Up to $100
Frames	Up to $130 allowance; 20% discount on additional cost	Up to $70
Covered Services – Contacts in lieu of Frames/Lenses		
Contacts – Medically Necessary	$0	Up to $210
Contacts – Elective	Up to $130	Up to $105
Benefit Frequency		
Exams	Once every calendar year	
Lenses	Once every calendar year	
Frames	Once every other calendar year	
Contacts	Once every calendar year	

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) offer you a great way to save money in taxes. The Health Care FSA and Dependent Care FSA let you set aside tax-free dollars—money taken out of your paycheck before income or Social Security taxes have been calculated—to pay for eligible health care and dependent care expenses. **There is no automatic re-enrollment for the Health Care FSA, Limited Purpose Health Care FSA or Dependent Care FSA plans. IRS rules require you to actively re-enroll in the FSAs each year if you want to use them.**

HEALTH CARE FSA

The Health Care FSA is for those employees who participate in the Kaiser Permanente HMO Plan, the Blue Shield HMO Plan, the Blue Shield Trio ACO HMO Plan, or the Blue Shield PPO Plan. The account is designed to help pay for eligible out-of-pocket health care expenses. You can contribute up to $2,650 per year pretax, however, your contributions are "use it or lose it" elections and expenses must occur within the plan year. Important: Over-the-counter medications are no longer covered without a prescription. Note: If you are a participant in an HSA, you are not eligible for the Health Care FSA reimbursement account.

LIMITED PURPOSE HEALTH CARE FSA

The Limited Purpose Health Care FSA is for employees enrolled in the Blue Shield HDHP with HSA medical plan option. The Limited Purpose Health Care FSA works the same way as the standard Health Care FSA: pretax contributions, "use it or lose it," elections and expenses must occur within the plan year. However, with the Limited Purpose Health Care FSA, you can only submit claims for eligible vision and dental expenses. You can contribute up to $2,650 annually to a Limited Purpose Health Care FSA.

DEPENDENT CARE FSA

The Dependent Care FSA lets you set aside pretax dollars to help pay for day care services for your eligible dependents. The maximum amount you can contribute is $5,000 per year, or $2,500 if married and filing separate tax returns.

Be sure to read the FSA brochures included in your enrollment materials for more details about these accounts. It's important to estimate your expenses conservatively—the law requires that you use your expenses during the plan year (the "use it or lose it" rule). Any unused money in the Health Care and Dependent Care FSA accounts at the end of the plan year will be forfeited.

COMMUTER ACCOUNTS

TRANSIT REIMBURSEMENT PLAN

The transit benefit allows employees to pay for, on a pretax basis, transit passes, ticket books, fare cards and vanpool costs. The maximum amount deductible on a pretax basis is $260 per month for commuter benefits. Once enrolled in this program you may change your election monthly.

PARKING REIMBURSEMENT PLAN

The parking benefit also allows you to pay your parking costs on a pretax basis. You can make your elections on a monthly basis as well. The maximum amount deductible pretax is $260 per month for qualified parking. Once enrolled in this program you may change your election monthly.

Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
Health Care Flexible Spending Account	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, co-insurance, deductibles, eyeglasses and doctor-prescribed over-the-counter medications)	You can contribute up to $2,650 per year pretax, however, your contributions are "use it or lose it" elections and expenses must occur within the plan year.	Saves on eligible expenses not covered by insurance, reduces your taxable income
Limited Purpose Health Care Flexible Spending Account	You can submit claims for eligible vision and dental expenses when used with an HDHP.	You can contribute up to $2,650 per year pretax, however, your contributions are "use it or lose it" elections and expenses must occur within the plan year.	Saves on eligible expenses not covered by insurance, reduces your taxable income
Dependent Care Flexible Spending Account**	Dependent care expenses (such as day care, after-school programs or elder care programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income
Transportation & Parking Benefit Plan Accounts	Transportation expenses include vanpools and mass transportation costs. Note: The cost of commuting solo is not an eligible expense. Parking expenses include costs for parking at mass transit facilities at or near your work location and where you pick up your carpool or vanpool.	You may designate up to $260 per month to your Transportation Account and up to $260 per month to your Parking Account.	Allows you to pay for transportation and parking expenses related to your daily commute to work on a pretax basis. This is the only pretax account that allows you to make changes to your monthly contribution during the plan year.

**Dependent eligibility rules apply when electing DCFSA

FSAs HELP YOU SAVE ON YOUR TAXES

Here's an example of how much you can save when you use the FSAs to pay for your predictable health care and dependent care expenses.

Account Type	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pretax contribution to Health Care FSA and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes	$11,701	$12,355
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses and taxes	$36,299	$35,645
Tax savings with the Health Care and Dependent Care FSAs	$654	N/A

Life and Accidental Death & Dismemberment (AD&D) Insurance

Life and AD&D coverage helps protect your loved ones in the event of your death or serious injury. Even if you're single, your beneficiary can use your Life insurance benefits to pay off your debts, such as credit cards, mortgages, and other final expenses.

Basic Life insurance and AD&D coverage are provided at no cost to you, and you're not required to enroll in any other health and protection program. You are automatically covered up to the amount of your annual salary, up to a maximum of $50,000. Coverage is provided for you through Prudential.

AD&D coverage provides a benefit to help protect you and your family from the financial hardship caused by accidental death or dismemberment. AD&D insurance provides you specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that death occurs from an accident, 100% of the AD&D benefit would be payable to your beneficiary(ies).

DESIGNATING A BENEFICIARY

Choosing a Life and AD&D beneficiary ensures that your benefits are paid according to your wishes in case of your death. You can name more than one beneficiary, and you can change beneficiaries at any time. If you name more than one beneficiary, indicate the benefit amount for each. Be sure all names are correct on the Beneficiaries Tab in the Benefits Worklet in Workday. Beneficiaries can be changed at any time, and should be confirmed annually at the least.

Disability Income Protection

If you become disabled for an extended period of time and cannot work, no benefit becomes more important to your financial security than disability income protection.

SHORT-TERM DISABILITY (CASDI)

Short-Term Disability (STD) is provided to employees residing in California through the California State Disability Insurance (CASDI) program. New in 2018 the rate of SDI will increase from 55% to 60% for employees earning more than one-third the average quarterly wage and to 70% for workers who earned less than one-third. Benefit begins after 7 days of disability. This benefit is reduced by other sources of disability income, and all benefits paid under this policy are subject to income tax. For additional information please contact **hr@cca.edu**.

VOLUNTARY LONG-TERM DISABILITY

CCA covers a portion of Long-Term Disability (LTD) coverage to employees through Prudential. LTD covers 60% of your base annual earnings to a monthly maximum of $3,000. Eligibility begins after one year of employment. Benefit begins after 180 days of disability and payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. Certain exclusions as well as pre-existing condition limitations may apply. For full plan details, please contact **benefits@cca.edu**.

VOLUNTARY LTD RATE CHART

	Monthly employee rate per $100
AGE	NON-SMOKER
<30	$0.026
30–39	$0.065
40–44	$0.113
45–49	$0.176
50–54	$0.256
55–59	$0.331
60–64	$0.234
65+	$0.117

Employee Assistance Program

The Employee Assistance Program (EAP) is a great resource that offers help and support for a variety of challenges.

The EAP is a voluntary program that offers free and confidential assessments, short-term counseling, referrals and follow-up services to employees who have personal and/or work-life balance issues. EAPs address a broad range of issues affecting mental and emotional well-being. With just one phone call, at any hour of the day or night, you can speak with helpful resources.

You and your eligible dependents or household members can receive assistance for the following:

- Marital and family relationships
- Job related stressors
- Stress, anxiety and depression
- Parent and child relationships
- Legal and financial counseling
- Identity theft counseling
- Financial planning
- Various other work or life challenges

Our provider is Claremont. The program includes up to 5 counseling sessions. If you need help or guidance, you may reach out to the EAP at 800-834-3773 or **www.claremonteap.com/pages/cap.html** and use company name: CCA

EAP Services Continued

WORK LIFE SERVICES

You have access to tools, resources and experts who can help with many of the day-to-day things that can happen in life. Unlimited access is provided to Claremont's Personal Advantage (CPA) for articles, resources, videos and assessments about health, finance (including Identity Theft consultation), legal issues, personal growth, stress, family life and more. Go to **www.claremonteap.com/pages/cap.html** and use company name: CCA

LEGAL ASSISTANCE PROGRAM

Your EAP program offers you quick and confidential access to help with legal or financial questions and services you may need. Legal and financial experts are available to help with any questions you may have, or access the online library for helpful tools and resources.

- **Legal Consultation:** Up to 30-minutes of free consultation is provided at no cost. A 25% discount is available for any service beyond the initial consultation. Telephonic or in-person consultation is available. Attorneys have expertise in areas such as family law, consumer issues, traffic violations and personal injury, etc. Free "Simple Will" kits are available upon request.
- **Financial Consultation:** An initial 30-60 minute consultation with a financial counselor is available at no cost. Financial specialists are able to assist employees/family members with budgeting, retirement planning, debt consolidation, ID Theft, financial planning, auto and real estate purchasing, etc. Free credit reports are provided upon request.

QUESTIONS?

Contact **benefits@cca.edu**.

Additional Benefits

CCA TUITION REMISSION

Regular employees, certain faculty* and their dependents (spouse, domestic partner, child or children) are eligible to take courses in the Regular Undergraduate and Extended Education Programs free of charge.

This policy does not extend to courses taken on a by-arrangement, and/or special tutoring basis. The number of courses available through tuition remission is dependent on the number of hours worked and length of service. Details are described in the CCA Tuition Remission policy document.

To apply for the Tuition Remission program please email **hr@cca.edu** for more information.

*Ranked faculty holding an annual teaching contract for three or more lines per academic year and unranked faculty who have accepted a one or two year appointment for three or more lines per academic year.

TIAA

CCA's Retirement Plans can provide you with the opportunity to save for retirement on a tax-advantaged basis and provide additional income for retirement. This plan is commonly referred to as a 403(b) plan or TSA (Tax Sheltered Annuity). CCA will match a participant's contributions up to 5% of your salary. CCA's contributions are 100% vested after two years of service.

In addition, the CCA Retirement Plan also gives you an opportunity to save for retirement on an after-tax or Roth basis. In basic terms, traditional 403(b) contributions are before tax and Roth contributions are after tax. You can contribute to one or both as long as you don't exceed the annual IRS limit for 2018 of $18,500.

Starting your retirement savings plan is a two-step process: First, visit **tiaa-cref.org/cca** to find useful tools and information as well as to enroll in the plan and make your investment elections. You may also call Client Participant Services directly at 800-842-2252. Second, initiate your payroll deductions from your Benefits Worklet in Workday.

For financial and retirement guidance CCA has engaged the services of Sage View Advisory Group. We have two representatives available for individual appointments:

- David Shnapek
  Phone: 408-757-4441
  Email: **dshnapek@sageviewadvisory.com**
- William Posch
  Phone: 650-446-3339
  Email: **wposch@sageviewadvisory.com**

Don't forget to designate a beneficiary for your HSA account! See page 16, "Designating a Beneficiary" for instructions.

Monthly Contribution Worksheet

Medical Coverage	Tier A <$60k		Tier B >$60k		
	2018 EMPLOYEE CONTRIBUTION	2018 EMPLOYER CONTRIBUTION	2018 EMPLOYEE CONTRIBUTION	2018 EMPLOYER CONTRIBUTION	YOUR MONTHLY COST
Kaiser Permanente HMO Plan					
Employee Only	$94.54	$644.94	$120.96	$618.52	$
Employee + 1	$338.42	$1,140.54	$394.84	$1,084.12	$
Family	$539.70	$1,553.03	$621.38	$1,471.35	$
Blue Shield HMO					
Employee Only	$85.34	$741.15	$110.78	$715.71	$
Employee + 1	$323.74	$1,411.89	$378.66	$1,356.97	$
Family	$519.30	$1,960.18	$598.78	$1,880.70	$
Blue Shield HMO Trio					
Employee Only	$42.68	$590.33	$55.38	$577.63	$
Employee + 1	$161.86	$1,168.04	$189.32	$1,140.58	$
Family	$259.66	$1,639.35	$299.40	$1,599.61	$
Blue Shield PPO					
Employee Only	$85.34	$838.41	$110.78	$812.97	$
Employee + 1	$323.74	$1,616.13	$378.66	$1,561.21	$
Family	$519.30	$2,251.95	$598.78	$2,172.47	$
Blue Shield HDHP					
Employee Only	$0.00	$618.99	$0.00	$618.99	$
Employee + 1	$0.00	$1,299.87	$0.00	$1,299.87	$
Family	$0.00	$1,856.97	$0.00	$1,856.97	$
Dental Coverage	Core PPO Plan		Buy-up PPO Plan		
	Tier A and Tier B Rates		Tier A and Tier B Rates		
Employee Only	$6.40	$42.57	$14.88	$41.81	$
Employee +1	$33.98	$53.34	$53.30	$47.82	$
Employee + Family	$58.40	$77.43	$105.04	$52.26	$
Vision Coverage – Tier A and Tier B Rates					
Employee Only	$1.50	$7.87			$
Employee +1	$5.00	$9.58			$
Employee + Family	$9.00	$14.12			$
Flexible Spending Account Contribution(s)					
Health Care	($220.83 Monthly Maximum Contribution up to a maximum of $2,650 per calendar year.)				$
Limited Health Care	($220.83 Monthly Maximum Contribution up to a maximum of $2,650 per calendar year.)				$
Dependent Care	($416.66 Monthly Maximum Contribution up to a maximum of $5,000 per calendar year.)				$
Commuter Plan	($260 Monthly Maximum Contribution, you may change your election monthly				$
Parking Plan	($260 Monthly Maximum Contribution, you may change your election monthly				$
Basic Life/AD&D					
Employee Only					Paid by CCA
Long-Term Disability					
Employee Only (See page 15 for rates)					$
Additional Benefits					
Employee Assistance Program **CCA Tuition Remission** **Provident Credit Union**					Paid by CCA
TIAA – 403(b)					$
Your Total 2018 Monthly Benefit Cost (not including 401(k) Contribution)					$

Note: Direct Deposit may be set up directly in Workday; click on the Pay Worklet, Payment Elections.

Important Contacts

Coverage	Plan Name	Phone	Website/Email
Medical	Kaiser Permanente HMO Group #: 7525	800-464-4000	**www.kp.org**
Medical	Blue Shield Group #: w0064038 HMO Group #: HMOX0001 PPO Group #: PPOX0001 HDHP Single Group #: PPOX0002 HDHP Family Group #: PPOX0003 Trio ACO HMO Group #: HMOX0002	800-393-6130	**www.blueshieldca.com**
Health Savings Account	Health Equity Group #: 20000028	866-382-3510	**www.healthequity.com**
Dental	Anthem Blue Cross Group #: 1546990009	800-627-0004	**www.anthem.com/ca**
Vision	VSP Group #: 12168187	800-877-7195	**www.vsp.com**
Flexible Spending Accounts and Commuter Benefits	Discovery Benefits	866-451-3399	**www.discoverybenefits.com**
Life and AD&D	Prudential Group #: 60378	888-598-5671	**www.prudential.com/link2benefits**
Disability	Prudential Group #: 60378	888-598-5671	**www.prudential.com/link2benefits**
Retirements	TIAA Plan #: 500713	800-842-2252	**www.tiaa-cref.org/cca**
Financial Guidance	Sage View Advisory Group	David Shnapek: 408-757-4441 William Posch: 650-446-3339	**dshnapek@sageviewadvisory.com** **wposch@sageviewadvisory.com**
Employee Assistance Program	Claremont	800-834-3773	**www.claremonteap.com**
CCA Benefits Helpline	Willis Towers Watson	510-594-3700 Option 1	**benefits@cca.edu**

Your Rights and Notices

PATIENT PROTECTION MODEL DISCLOSURE

Blue Shield and Kaiser HMO plans generally require 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, Blue Shield or Kaiser 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 Blue Shield www.bluesheildca.com or Kaiser www.kp.org. For children, you may designate a pediatrician as the primary care provider.

HIPAA SPECIAL ENROLLMENT NOTICE

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). 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).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, 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 may 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 may not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraphs above, however, regarding enrollment in the event of marriage, birth, adoption, placement for adoption, loss of eligibility for Medicaid or a state CHIP, and gaining eligibility for a state premium assistance subsidy through Medicaid or a state CHIP.)

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICES

Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

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 Blue Shield and Kaiser coverage may be affected.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage/**), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Blue Shield and Kaiser coverage, be aware that you and your dependents may not 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 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 The Company 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).

COBRA CONTINUATION COVERAGE GENERAL NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to: Human Resources.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

California College of The Arts (the "Plan") provides health benefits to eligible employees of the Company and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

RECEIPT OF YOUR PHI BY THE COMPANY AND BUSINESS ASSOCIATES

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation: The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

AUTHORIZATION TO USE OR DISCLOSE YOUR PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

THE PLAN MAY CONTACT YOU

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred

more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

COMPLAINTS

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

The Plan has designated a Privacy Official as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. Please contact HR for further information.

Notes

Notes

This brochure highlights the main features of the California College of the Arts Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. California College of the Arts reserves the right to change or discontinue its employee benefits plans at any time.

California College of the Arts